Torbay and South Devon NHS Foundation Trust
Public Board of Directors

Board Room, Hengrave House, Torbay Hospital, Lowes Bridge, Torquay, TQ2 7AA

5 February 2020 09:00 - 5 February 2020 11:00

AGENDA

#	Description	Owner	Time
	In case of fire - if the fire alarm sounds please exit the Board Room immediately in a calm and orderly fashion. On exiting, turn left, exit the building through the sliding doors and assemble in Hengrave House Car Park.		
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2	PART A: Matters for Discussion/Decision		
2.1	Apologies for Absence - Professor Chris Balch (Non-Executive Director), Mrs Lesley Darke,Director of Estates and Commercial Development Note	Ch	
2.2	Declaration of Interests Note	Ch	
2.3	Minutes of the Board Meeting held on the 4th December 2019 and Outstanding Actions Approve 19.12.04 - Board of Directors Minutes Public.pdf 11	Ch	
2.4	Report of the Chairman Note	Ch	
2.5	Report of the Chief Executive Review Report of the Chief Executive.pdf 25	CE	
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2.8	Maternity Governance Safety Report Receive and Note Maternity Governance Safety Report.pdf 91	CN	
2.9	Midwifery Staffing Oversight Report Receive and Note Midwifery Staffing Oversight Report.pdf 99	CN	
2.10	Mortality Safety Scorecard Information Mortality Safety Scorecard.pdf 111	MD	
2.11	Assurance Framework for Seven Day Hospital Services Information Assurance Framework for Seven Day Hospital Serv... 125	MD	
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2.13	Quality Assurance Committee Terms of Reference Approve Quality Assurance Committee Terms of Reference.... 169	CS	
3	PART B: Matters for Approval/Noting Without Discussion		
3.1	Reports from Board Committees		
3.1.1	Quality Assurance Committee - 3rd December 2019 and 22nd January 2020 Information	Ch	

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3.1.3	Finance, Performance and Digital Committee - 17 December 2019 and 28th January 2020 Information Finance Performance and Digital Committee 17th D... 181 Finance Performance and Digital Committee 28th J... 183	Ch	
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3.2.2	Trust Quality Accounts Receive and Note Trust Quality Accounts.pdf 199	CN	
3.2.3	Chief Operating Officer Report Receive and Note Report of the Chief Operating Officer.pdf 205	COO	
3.2.4	Report of the Director of Workforce and Organisational Development Receive and Note Report of the Director of Workforce and Organisatio... 213	DWOD	
3.2.5	Report of the Director of Estates and Commercial Development Receive and Note Report of the Director of Estates and Commercial D... 223	DECD	
4	Compliance Issues		
5	Any Other Business Notified in Advance	Ch	

#	Description	Owner	Time
6	Date of Next Meeting - 9.00 am, Wednesday 4th March 2020	Ch	
7	Exclusion of the Public	Ch	

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BOARD CORPORATE OBJECTIVES

Corporate Objective:

1. Safe, quality care and best experience
2. Improved wellbeing through partnership
3. Valuing our workforce
4. Well led

Corporate Risk / Theme

1. Available capital resources are insufficient to fund high risk / high priority infrastructure / equipment requirements / IT Infrastructure and IT systems.
2. Failure to achieve key performance / quality standards.
3. Inability to recruit / retain staff in sufficient number / quality to maintain service provision.
4. Lack of available Care Home / Domiciliary Care capacity of the right specification / quality.
5. Failure to achieve financial plan.
6. Care Quality Commission's rating 'requires improvement' and the inability to deliver sufficient progress to achieve 'good' or 'outstanding'.

Torbay and South Devon
NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
PUBLIC BOARD OF DIRECTORS MEETING
HELD IN THE BOARD ROOM, TORBAY HOSPITAL
ON WEDNESDAY 4TH DECEMBER 2019

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	Professor C Balch	Non-Executive Director
	Mrs V Matthews	Non-Executive Director
	Mr R Sutton	Non-Executive Director
	Mr P Richards	Non-Executive Director
	(Mrs S Taylor	Non-Executive Director)
	Mr Jon Welch	Non-Executive Director
	Ms L Davenport	Chief Executive
	Mr I Currie	Acting Medical Director
	Mr J Harrison	Chief Operating Officer
	(Ms A Jones	Director of Transformation and Partnerships)
	Mr D Killoran	Interim Director of Finance
	Mrs J Viner	Chief Nurse
	Mrs J Stockman	Torbay Council Representative
In attendance:	Mrs J Downes	Company Secretary
	Mrs M Trist	Corporate Governance Manager
	Mr D Armitage	Associate Director Workforce & OD
	(Ms M O'Neill	Matron)

( ) = Present for part meeting

Governors:	Mrs W Marshfield	Mr S Harding	Mrs L Hookings
	Mrs M Lewis		

Before the start of the meeting, Chairman reminded the Board that there was currently a period of Purdah, in the lead up to 12 December General Election

		ACTION
198/12/19	**Board Corporate Objectives** The Board noted the Corporate Objectives.	
199/12/19	**User Experience story** Michelle O'Neill, Modern Matron Cardiology (Dunlop Ward), presented the	

patient story that illustrated a project to enable reduced lengths of stay for Heart Failure patients.

The normal length of stay for Heart Failure patients would be two to three weeks, and the pilot was set up to look at the possibility of enabling an earlier discharge by managing patients differently. Patients once stabilised receive a four to six hour infusion on the ward, and the pilot, working with Cardiologists and Specialist Nurses, looked to enable them to receive this treatment on a daily basis on the ward, rather than as an in-patient.

Ms O'Neill provided some case studies from the pilot:-

Patient 1 – Had been admitted to be stabilised but wanted to return home. She was discharged after a few days but attended daily for infusion and a review by specialist nurses, accompanied by her husband to discuss her future treatment. Although nervous at first, owing the regular monitoring received this patient was making a good recovery, and felt extremely positive about her experience – normally a patient such as Patient 1 would have been an inpatient for 17 days.

Director of Transformation and Partnerships joined the meeting at this stage.

Four other patients (who would have been 17 to 20 day stay patients) had also been involved with the pilot. These were more complex cases with varying health issues, but with appropriate specialist advice they are also responding well and none of the patients have been re-admitted.

Cardiology is now reviewing this pilot, and it is hoped to continue with this innovative practice. The patient feedback had been excellent, as the patients involved preferred to be at home, provided they were given appropriate support and information when they did attend the ward.

The Board congratulated Ms O'Neill on the success of the pilot and the innovative approach adopted.

Mrs Lyttle said that ambulatory care pathways were being set up for Heart Failure patients in Belfast and she would be happy to provide Ms O'Neill with contact details.

Mr Balch asked if certain factors made some patients more suitable for the pilot, and whether any problems had arisen regarding the daily hospital visits. Ms O'Neill confirmed that most patients were accompanied by a carer or family member and they had made their own transport arrangements: the only additional equipment requirements would be for appropriate chairs for patients to use for their daily treatments.

Chief Nurse asked about the views of the pilot patients' families and Ms O' Neill confirmed that sometimes they were more anxious than the patient, who were just keen to leave hospital and return home. Difficulties were addressed on a case by case basis, with families and hospital staff working together to provide the best care for the patient. For this reason, various other services had been involved, but this also varied from case to case.

The Chairman thanked Ms O'Neill for attending to present this patient story

and offered congratulations on behalf of the Board on the success of the pilot.

PART A: Matters for Discussion/Decision

199/12/19 **Apologies for Absence**

Apologies were received from Mrs Lesley Darke (Director of Estates and Commercial Development) and Dr Rob Dyer, Medical Director.

200/12/19 **Declaration of Interests**

There were no declarations of interests

201/12/19 **Minutes of the Board Meeting held on 6th November 2019 and Outstanding Actions**

The Board approved the minutes of the Board meeting held on 6 November 2019.

There were no outstanding actions.

202/12/19 **Report of the Chairman**

The Chairman briefed the Board as follows:-

- Chairman reported on a very well attended Governors' Network meeting held at Newton Abbot hospital. These meetings were developing well and Chairman thanked the Chief Operating Officer and his operational team for their valuable input to ensure that governors were kept informed of developments within the Trust and commended the Network meetings to Board members too.

- Chairman was pleased to advise the Board that he had recently chaired several Consultant interview panels and all applicants had expressed a clear desire to come specifically to this Trust.

- A very well planned Carers Rights event had been held on 21 November, organised by Katy Heard – the Chairman thanked Annie Hall, Governor, who had also attended

- Chairman advised the Board of the appointment of the Trust's new Counter-Fraud specialist, Adele Rilstone, had recently been appointed and her ideas on development of the role.

- STP activity had taken place at all levels and the Trust's support for continuing that development of the STP

- On 3 November a well-attended Staff Heroes event had taken place. The Chairman thanked Governors Lynne Hookings and Annie Hall for being part of the judging panel for this well-valued process.

203/12/19 **Report of the Chief Executive**

The Chief Executive drew the Board's attention to the following from her

report, reminding members that because of purdah, the report would be brief.

- The Trust is a national leader in providing surgical procedures as day cases, Heart failure patients being the latest to benefit from a day treatment approach. A successful pilot had taken place to treat a small group of patients as day case outpatients who would normally have spent several weeks as inpatients.

- In order to unlock capacity across the system and relieve continuing operational pressures the Trust has been looking to discharge medically fit patients safely, quickly and earlier. For a two-week period at end November our senior managers supported specialty areas on the front line speaking to staff and identifying problems , with lessons learned being fed into the winter planning process.

- Four non-Executive appointments had recently been made to the governing body of NHS Devon CCG, one of whom was an advocate of mental health issues.

Chief Executive was delighted to report that Mr Stuart Andrews had been elected as national lead for benign upper gastrointestinal services by the Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland.

A new programme is being run specifically for health and social care staff who may be feeling stressed, o overwhelmed, anxious or depressed. The six-week “Help to Overcome Problems Effectively” (HOPE) programme were free to attend and supports individuals to manage their health and wellbeing.

The Chief Executive asked members to note that the CQC has published the results of its 2018 Urgent and Emergency Care Survey - covering 132 NHS acute trusts in England, asking people about their experiences of urgent and emergency care in major consultant-led accident and emergency departments (Type 1) and also minor injury units or urgent care centres (Type 3) run directly by an acute hospital trust. For both reports, TSDFT was rated as good, with patient satisfaction scores generally the same as for most other Trusts. Of note was that our Minor Injury Units were rated better than most other Trusts for environment and facilities and respect and dignity.

The Board received the report of the Chief Executive.

204/12/19 **Integrated Performance Report (IPR) – Month 7**

The IPR sets out the headline performance for Month 7 (October) 2019/20 against the key quality and safety, workforce, performance, and financial standards that together represent the Trust’s Operational Plan for 2019/20.

As one of the 21 Trusts named in the second wave of the Health Infrastructure Plan (HIP) round 2, the Trust had submitted at the end of November its request for £3.5m of allocated seedfunding for the development of a Strategic Outline Case.

Performance: against the national NHS I Single Oversight Framework:
In October, the Trust did not meet the following national performance standards or agreed planned improvement trajectories:

- **A&E:** STF Trajectory (90%) not met with performance for October at 82.7%.
- **RTT:** RTT performance has seen little change in October with 79.3% of people waiting less than 18 weeks, behind the Operational Plan trajectory of 82%. Against 52 weeks there has been a decrease from 89 patients waiting last month to 79 patients this month; this was within our plan trajectory of 110.
- **Cancer:** National standard not met in October with 72.1% against standard of 85% and improvement trajectory (85.1%). Recovery plans to deliver standard in Q3 were in place with weekly monitoring and escalation through Chief Operating Officer.
- **Diagnostics:** The diagnostics trajectory was not met with 90% of patients waiting under 6 weeks. This is outside of the Trust's recovery trajectory to deliver improved performance in October to achieve 91.7% against the National standard 99%.
- **Dementia:** The Dementia Find standard was reported at 85.1%, therefore, not achieving the 90% standard.

Financial performance against 2019/20 plan:

- The Trust has a Control Total for the year of a deficit of £3.80m, which excluded income relating to Provider Sustainability Fund (PSF) and Marginal Rate Emergency Tariff (MRET) totalling £8.36m.
- In Month 6 the Trust formally reported a variance to plan of £15.0m after expected mitigations. The position at Month 7 showed a net adverse movement of £0.2m which was expected to be fully mitigated by further stretch target of £0.2m. The variance to plan was therefore still the same at £15.0m.
- The financial position at Control Total level as at 31st of October 2019 was a £8.39m deficit, which is £1.20m adverse against the plan of £7.19m. As the Trust had implemented the protocol for changing control total an adverse movement was expected.
  (52 week fines have been assumed to be returned in full or not applied, no STP risk share had been applied at months 1 to 7, and discussions were continuing with Torbay Council over its contributions to Adult Social Care in 2019/20).
- In months 1 to 6 the Trust had assumed it would earn the PSF and MRET funding of £3.51m (as the Trust delivered the control total in that period). From Month 7 onwards, only MRET income is assumed due to projected non delivery of control total.
- Total pay run rate in Month 7 (£21.0m) was lower in comparison to previous month (Month 6 £21.1m); mainly lower Agency spend.
- Non pay expenditure run rate of £19.6m was higher by £1.4m compared to Month 6 (£18.2m). Higher spend in Month 7 was due to: Drugs £0.2m pass through (income is received), Clinical supplies £0.2m - medical and surgical equipment, devices and consumables, social care cost £0.2m due to supported living and long stay nursing, Health visitor £0.1m, education and training cost £0.1m (matched by income), net increase in CFHD cost £0.2m, STP resourcing £0.2m and IT software cost £0.2m.

- The Cost Improvement Plan (CIP) target for year to date was £7.0m of which £5.4m had been delivered; an adverse variance of £1.6m due to undelivered pay schemes offset by non-pay schemes.
- The Trust had an annual savings target of £20.0m of which £9.1m have targets identified resulting in a £10.9m gap.
- The capital expenditure as at Month 7 is £5.1m which was £2.9m underspent against the budget of £8.1m. The full year forecasted spend was £17.2m which would result in a £0.4m overspend.

As previously forecast, the Finance Risk Rating has dropped to 4 at Month 7. This was due to the adverse Social Care Indicator position and adverse agency spend.

The Chief Operating Officer confirmed some key points from the IPR in relation to Performance: - he had greater confidence in achieving zero 52-week waits by end March and additional funding had been received from commissioners to help reduce Endoscopy waiting lists.

Councillor Stockman asked how the current performance and financial position compared to the previous year, and the Chief Operating Officer confirmed that historical data was now included in the IPR, although the position for long wait patients had deteriorated owing to 11 months of Theatre closures resulting in a 20% loss of capacity. The waiting list position was broadly similar to the same time in 2018. Interim Director of Finance said it would be difficult to compare the financial data for the two years, owing to the different contractual arrangements now in place and he offered to discuss this with Cllr Stockman outside the meeting. Interim DoF

Mrs Lyttle said she was able to provide further assurance to the Board in respect of operational performance as reports had been brought to the 3 December Quality Assurance Committee meeting, which provided information on how various performance issues were being addressed and on how patient quality and experience were being monitored. Mrs Lyttle was pleased to note the improved position, and asked whether levels of both inpatient and outpatient activity had increased compared to 2018. The Chief Operating Officer advised he was currently seeking clarification on this, and would arrange to bring an update to February Board. COO Mr Balch, as Chair of Finance, Performance and Digital committee (FPDC), confirmed that a good report had recently brought providing the committee with assurance on Diagnostics, the measures now in place and progress being made to improve the current position. The Chief Operating Officer had confirmed that the diagnostic wait position had improved from 10% to 7%.

Interim Director of Finance confirmed the key points from the IPR in relation to finance, with a current £15m variance from the initial plan and £7.2m behind plan at end October. Interim Director of Finance was pleased to advise the Board of a positive positon with regard to pay run rate (reduced by £100k in-month); work was ongoing in the Integrated Service Units (ISUs) to reduce agency spend and with regard to CIP delivery, the ISUs were forecasting £9.1m delivery by year end.

Mrs Taylor joined the meeting at this stage.

Interim Director of Finance drew members' attention to the Summary of

Financial Forecast included at page 41 of the IPR and informed the Board of further recovery actions being undertaken with the local system, full details would be brought to December FPDC.

Mrs Matthews and Mrs Lyttle asked about CIP progress, with particular reference to the breakdown between recurrent and non-recurrent CIP. It was accepted that good plans were in place, but the NEDs sought assurance that appropriate support was being provided to teams to enable delivery in projected timescales. Director of Transformation and Partnerships confirmed that the Programme Director had reviewed all schemes to identify the level of support required to ensure delivery. Mr Balch said that the financial grip and control processes now in place were leading to better financial control.

The Chairman felt that the financial Report provided was more positive, and he asked that the Interim Director of Finance extend his thanks and those of the Board to the Finance Team for the work being undertaken and the good progress made, and these thanks were echoed by the Chief Executive.

The Chief Executive said there would be greater vigour around the 2020/21 business planning process, and it would be essential to have well-developed plans in place before the start of the financial year.

Moving to the Workforce section of the IPR, Mr Armitage said that work was currently being undertaken to analyse and validate the sickness absence data and several measures were in place to improve staff health and wellbeing. The Chief Executive commented that staff had been working hard for a sustained period, and it was very important to focus on their health and wellbeing. Mr Armitage confirmed this issue would be discussed in detail at the December meeting of the People Committee. Mrs Matthews confirmed that the People Committee would also be looking at the issue of stress in Emergency Department (ED) staff and she would report back to the Board. Chief Executive reported on ongoing meetings with Freedom to Speak Up Guardians and the HR team to review issues in ED. Chairman felt it important to consider workforce issues across the whole Trust, not just in the Acute hospital. Mrs Lyttle confirmed that various workforce challenges would be discussed at Quality Assurance Committee and People Committee.

The Board received and noted the Integrated Performance Report for Month 7.

205/12/19 **Mortality Safety Scorecard**

The Board received the Mortality Safety Scorecard.

206/12/19 **Health Care Worker Flu Immunisation Programme**

The report provided assurance on the health care worker flu immunisation programme in place within the organisation for 2019/20. This included a completed healthcare worker flu immunisation best practice management check list for Board consideration provided by NHS England and NHS Improvement.

AD Workforce and OD reported on a range of actions introduced to support the Flu campaign, and was pleased to report that the level of immunisations

currently exceeded the 2018 figure at the same point. Chairman asked about the availability of vaccines and Chief Executive congratulated the team on a good performance to date: she would like to see the take up rate increase to over 80%, in order to ensure staff availability to help deal with winter pressures. There was also a campaign to improve take-up in Care Homes.

The Trust Board received the Health Care Worker Flu Immunisation Programme Report.

207/12/19 **Guardian of Safe Working Hours Report**

The report provided assurance that doctors in training under the new terms and conditions of service were working safe working hours and to highlight any areas of concern. Mrs Lyttle asked about the Haematology exceptions reported by Junior Doctors and asked whether this was representative of their workforce. The Acting Medical Director commented that this was a very small department, which may have distorted the figures but he would review this issue and provide a further report. Acting MD

Chief Executive confirmed that a solution was being sought to the TOIL/Payment difficulties, in order to maintain morale and improve the situation moving forward.

The Board noted the Guardian of Safe Working Hours Report for information.

208/12/19 **Research and Development Annual Report**

The report, covering the period 2018/19 and up to Quarter 2 2019/20 provided a summary of the Trust's activity, performance and delivery against Government metrics set for Research and Development in the NHS; as part of the National Institute for Health Research (NIHR) contracts / Department of Health and Social Care and social Care HSC Research Strategy and agendas.

The Chairman thanked the Medical Director for a well-written report. Mrs Mathews asked whether Research would be mapped against the Clinical Services Strategy. The Acting Medical Director explained that each team had their individual approach to research, with a principal investigator needing to be appointed for each piece of research.

Mrs Matthews asked if the Trust's research ambitions matched our service resources and would be mapped against the clinical Services Strategy.

The Chief Nurse advised that a non-medical research programme was still being developed, including social work research and other possible areas of research for multi-disciplinary teams and non bed-based care. Chief Executive said she would look to address the decrease in research activity as described in the report. Elizabeth Welch was the new Research and Development champion and the Chief Executive had produced a video blog with her which will be available shortly to encourage further research opportunities throughout the Trust. Mr Balch felt that a more strategic approach to research was required. Mr Sutton asked about research activity undertaken by Torbay Pharmaceuticals and Director of Transformation and

Partnerships confirmed that a funding proposal was being discussed. Chairman confirmed that the opportunity for Research and Development was one of the attractions tor consultants wishing to join the Trust.

The Board received and noted the Research and Development Annual Report.

PART B: Matters for Approval/Noting without Discussion

Reports from Board Committees

209/12/19 **Charitable Funds Committee Terms of Reference**

The Charitable Funds Committee had undertaken a review of the Terms of Reference and were agreed at the committee meeting held on 13 November 2019.

The Board of Directors, acting in their capacity as Corporate Trustee, were asked to approve the Terms of Reference of the Charitable Funds Committee.

Chairman thanked the Company Secretary for the work undertaken in reviewing the Terms of Reference.

The Board approved the revised Terms of Reference for the Charitable Funds Committee.

210/12/19 **Charitable Funds Committee – 13th November 2019**

Mrs Lyttle briefed the Board on the meeting held on 13 November 2019 confirmed that no new risks had been identified.

211/12/19 **Finance, Performance and Digital Committee – 26th November 2019**

Mr Balch had nothing further to add to his report and no questions were received.

The reports from Board Committees were received and noted.

Reports from Executive Directors

212/12/19 **Safe Staffing and Nursing Work Programme**

The Board noted the Safe Staffing and Nursing Work Programme.

213/12/19 **Learning Disability Improvement Standards Report**

The Report gave a summary of TSDFT's current position in relation to the key findings from the NHSI Benchmarking exercise (July 2019) completed using the Learning Disability improvement standards.

The Chief Nurse said that the proposed recommendations would help raise the profile of the governance structure around learning disabilities and

improve the experience of nurses working with patients with a learning disability. Chief Executive thanked Chief Nurse and her team for the work undertaken to date, and said this was an area of current national focus.

The Board received and noted the Learning Disability Improvement Standards Report.

214/12/19 **Infection Prevention Control Update**

The report was being presented because the data on Clostridium Difficile Infection (CDI) presented at the Quality Improvement Group (QIG) was flagged as red. Of note was the following information:-

- The CDI data presented at QIG and Board reflected the 2018/19 target definitions not the 2019/20 definitions. NHSI changed the CDI target in 2019/20 to 36 CDIs, from 18 CDIs in 2018/19.
- The reason NHSI changed the target was because it changed the reporting definitions for Healthcare Acquired CDI in 2019/20 and this was to align England and Wales with USA and European definitions.
- NHSI and the CCGs were aware that this change in CDI definition in 2019/20 will more than double the reported numbers of Healthcare Acquired CDI in 2019/20 compared with 2018/19.

The update on blood stream infections (BSI) is in response to recent Public Health data that shows the Trust to be an outlier for Escherichia Coli, Methicillin Sensitive Staphylococcus Aureus (MSSA) and MRSA incidence. There are two main reasons that make the Trust an outlier for E. coli, MSSA and Methicillin Resistant Staphylococcus Aureus MRSA BSIs:
The Public Health England (PHE)'s Fingertips data is not "Age Adjusted" and the Trust is 'Sepsis Aware', and has a higher compliance with taking blood cultures when compared with other trusts and this leads to ascertainment.

Chief Nurse, Lead Director for Infection Control, highlighted key areas from the report to the Board. She said that appropriate infection control reports were made to the CQC and NHSI as required. Mrs Lyttle confirmed a discussion which had taken place at Quality Assurance Committee in that the Trust undertook a higher rate of testing than many other Trusts including in the community and therefore a greater incidence of infection control incidents was identified.

The Board received the Infection Prevention Control Update Report.

215/12/19 **Chief Operating Officer Report**

The Chief Operating Officer advised he had covered key areas from his report during the discussion on performance and the IPR (minute 204/12/19 refers)

The Chief Nurse advised of a slight dip in Dementia Find performance which was against the usual trend. She was reviewing the information and would advise the Board on progress. CN

Director of Transformation and Partnerships said that she was the on-call director and described the silver system reset which was helping to improve discharges and the patient flow, which would help in turn to improve overall

performance, and will be seen from the data in future reports. Acting Medical Director confirmed that the average length of stay was the lowest for a considerable time.

216/12/19 **Report of the Director of Workforce and Organisational Development**

The Report provided an update on the activity and plans of the Workforce and Organisational Development (OD) Directorate and assurance on workforce and organisational development issues.

Chairman thanked Associate Director of Workforce and OD for a very comprehensive report. It was clear that a range of activities were being undertaken to help support various workforce issues and especially to improve staff health and wellbeing.

The Board noted the report of the Director of Workforce and Organisational Development.

217/12/19 **Report of the Director of Estates and Commercial Development**

The Report provided an update on EFM key issues, performance and compliance for September and October 2019. Of note was information relating to the estates Infrastructure failures resulting in an interruption to service

EFM KPIs
EFM key performance indicators remain good across all areas with all estates statutory and mandatory planned preventative maintenance having met all standards. An example of the impact of the recent Trust wide IT failure could be seen in the performance figures for portering in month. The service saw an increase in demand of 754 additional requests.

Mr Welch drew attention to the trend graph showing an increase in the number of estates failures through lack of available capital. It was noted that the Regulator was aware of the number of incidents and were routinely updated on such estates failures.

The Board received and noted the report of the Director of Estates and Commercial Development.

218/12/19 **Compliance Issues**

None

219/12/19 **Any Other Business Notified in Advance**

None

Chairman advised the Board that although no Board meeting was scheduled for January, once the Regulator's response to the system plan was received,

it may be necessary to convene an additional meeting to discuss this issue.

Chairman took the opportunity to wish all present the compliments of the season.

220/12/19 **Date of Next Meeting – 9.00 am, Wednesday 5th February 2019**

Exclusion of the Public

It was resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

BOARD OF DIRECTORS

PUBLIC

No	Issue	Lead	Progress since last meeting	Matter Arising From
1.	CN to present report to Board on CDiff lapses in care.	CN	**Report to December Private Board**	06/11/19 **closed**
1.	Speak to Cllr Stockman regarding comparison of 2019 and 2018 financial position	Int DoF		4/12/19
2.	Report back to February Board on 2019 and 2018 inpatient and outpatient activity levels	COO		4/12/19
3.	Review Safe Working Hours report re Haematology and report back	Acting MD		4/12/19
4.	Review Dementia Find data and report back	CN		4/12/19

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's Report			**Meeting date**: 5 February 2020
Report appendix	n/a		
Report sponsor	Chief Executive		
Report author	Director of Transformation and Partnerships Joint Heads of Communication		
Report provenance	Reviewed by Executive Directors 28 January 2020		
Purpose of the report and key issues for consideration/decision	To provide an update from the Chief Executive on key corporate matters, local system and national initiatives and developments since the previous Board meeting.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board are asked to receive and note the Chief Executive's Report		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership	X	**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	X	**Risk score**	25
Risk Register	X	**Risk score**	25

External standards affected by this report and associated risks

Care Quality Commission	X	**Terms of Authorisation**	X
NHS Improvement	X	**Legislation**	
NHS England	X	**National policy/guidance**	X

- Available capital resources are insufficient to fund high risk/high priority infrastructure/equipment requirements/IT Infrastructure and IT systems.
- Failure to achieve key performance standards.
- Failure to achieve financial plan.

Report title: Chief Executive's Report		Meeting date: 5 February 2020
Report sponsor	Chief Executive	
Report author	Director of Transformation and Partnerships Joint Heads of Communication	

1 Trust key issues and developments update

Key developments to draw to the attention of the Board since the last Board of Directors meeting held on 4 December 2019 are as follows:

1.1 Safe Care, Best Experience

1.1.1 Coroner's Inquest

Tragically a 14 year old girl died in October 2018 following an general anaesthetic at Torbay Hospital. The girl had been under the care of paediatric care at Torbay Hospital as well as University Hospitals Bristol. As with any unexpected death the Trust informed the Healthcare Safety Investigation Branch (HSIB) and also commissioned an independent investigation from Niche Health and Social Care Consulting. Both reports stated that the girl sadly died as a result of complications due to an undiagnosed pre-existing condition. The investigations found that the Trust had acted in accordance with standard guidelines and procedures.

In December the coroner's inquest considered the facts and concluded that her medical management was lacking in that investigations to diagnose her underlying condition were not undertaken.

Comment: There is some clear learning from this tragic death and we are working with University Hospitals Bristol to improve the communication and co-ordination of care. As a Trust we continue to offer our deepest sympathies to the family for the tragic death of their daughter.

1.1.2 Dartmouth Health and Wellbeing Centre plans

Local people attended a drop-in session in December to see and discuss the design of the new health and wellbeing centre prior to the formal submission for planning. There was a broad range of views and comments, with some really helpful feedback. A number of people made positive comments on the layout, application of plans, natural light and overall design, and thought the development very exciting. There was an overwhelming view of encouragement to move forward with the plans and the development as soon as possible to benefit local people. All the comments made on the design are being considered by the Trust and its architects as they develop the detailed plans for a submission to the planning committee at South Hams District Council at the end of February 2020.

Comment: We are fully committed to continuing to engage with local people on the developments of the Health and Wellbeing centre in Dartmouth

1.1.3 Additional capital funding to improve emergency care

The Trust has been advised that it has been given access to Winter Pressure Capital funds totalling £905,000.

- £500,000 of that is for the refurbishment of the Trust's old ICU environment to enable a Non-Elective Surgical Assessment Unit to be established. This will ease the pressure on the Trust's Emergency Department, improve patient flow and experience.
- A further £365,000 is being invested in Medical Equipment to enable quicker diagnosis of patients, make better use of our theatres (used for both non-elective and elective work) and therefore again improve patient flow.
- Finally, £40,000 is being invested in an IT system that will enable the Trust to improve the tracking of 'Emergency take' patients more effectively, improves the audit trail, results in a quicker turn around for the creation of the patients discharge summary and also frees up clinical staff's time.

1.1.4 Coronavirus

There are currently no confirmed cases in the UK or of UK citizens abroad, and the risk to the public is low. The government is monitoring the situation closely and will continue to work with the World Health Organization (WHO) and the international community. However, we have received guidance from NHS England and Public Health England around the Coronavirus which has been confirmed in Wuhan in China. We have reviewed this guidance to ensure we are properly prepared if there were any cases locally.

1.2 Well Led

1.2.1 New Chief Finance Officer joins Trust

We are pleased to welcome Dave Stacey, who joined the Trust as our new Chief Finance Officer in January. Dave, who has a wealth of experience with a background in senior NHS roles joins us from North Middlesex University Hospital where he was Director of Finance. His previous roles include Director of Strategy at West London Mental Health Trust, England's biggest mental health trust and Deputy Director of transformation at Chelsea and Westminster Hospital NHS FT.

Dave Killoran, who has been acting in the interim role since the beginning of August made a significant contribution to the work of the organisation with his substantial experience and expertise in financial improvement and planning. We would like to thank him for his hard work in providing leadership and direction for the financial agenda of the Trust.

1.3 Valuing our Workforce, Paid and Unpaid

1.3.1 Chief Nursing Officer awards and visit

The World Health Organization (WHO) has designated 2020 as international Year of the Nurse and Midwife, in honour of the 200th anniversary of Florence Nightingale's birth. We started the year with a visit from Ruth May, Chief Nursing Officer for England, this week. Our Chief Nurse, Jane Viner, updated her on our progress with the 'Pathways to Excellence' programme. Ruth presented some of our nursing staff with Silver awards which recognise major contributions to patients and the profession, for nurses and

midwives. She also met teams on our ED, ICU and paediatric ward and discussed and shared with them her vision for collective leadership.

Comment: We are very proud that Silver Awards were made to:

- Gemma Guppy, a Quality Assurance Nurse
- Team Award for the Trust's Lower Limb Therapy Service
- Phineas, a Charge nurse in the Trust's Coronary Care Unit

2. Chief Executive Engagement: December/January

I continue to meet with external stakeholders and partners. Meetings I have attended during December and January are shown below.

Internal	External

• Director of Infection Prevention and Control
• Discharge Team Visit
• Child and Family Health visit – Capital Court
• Staff Side
• Video blog sessions:
  o HCA
  o Christmas and New Year messages
  o Blue Monday
	• Head of Peninsula Medical School
	• Delegates from Singapore
	• Chief Officer for Adult Care and Health, DCC
	• South West Regional Director, NHSE/I
	• Children and Young Persons Partnership Board
	• National Leadership Forum
	• Royal United Hospitals Bath
	• Devon A&E Delivery Board
	• STP Chief Executives' Meeting
	• STP Programme Delivery Executive Group
	• Devon ICM Meeting

3. Local Health and Care Economy Developments

3.1 Partner and partnership updates

3.1.1 Devon Strategic Transformation Partnership

STP chief nurse appointed

Darryn Allcorn has been appointed to the joint STP/CCG role of chief nurse. Darryn will take up the role from Northern Devon Healthcare Trust, where he fulfilled a similar role and will be a member of the CCG's executive team and sit on its Governing Body.

3.1.2 Devon CCG

NDHT and RD&E agree to explore joining together on a more formal basis
The Boards of Northern Devon Healthcare NHS Trust and the Royal Devon and Exeter NHS Foundation Trust have agreed that the two organisations will explore joining together on a more formal basis. Both Boards have agreed that this process must be based on the premise that any new arrangement is beneficial to people in all the communities served by both Trusts and this premise is supported by NHS regulators.

3.1.3 South West Academic Health Science Network

South West Academic Health Science Network Appoints new Chief Executive
The South West Academic Health Science Network (SW AHSN) has announced it has appointed a new chief executive, Jon Siddall. Jon has a wide background in multi-disciplinary teams and partnerships and scaling solutions to improve the health of people. He joins SWAHSN on 20 April with the aim of reconnecting and forging new links across the South West.

4. National Developments and Publications

Details of the main national and regional developments and publications since the last Board meeting on 4 December have been circulated to the Board through the weekly developments update briefings.

The items of particular note that I wish to draw to the attention of the Board follow.

4.1 Care Quality Commission

4.1.1 CQC submission complete

In December we responded on time to the CQC's provider information request. Thanks to the hard work of staff across the Trust we were able to meet this requirement which is the first step to a CQC inspection. We expect to receive an unannounced visit from the CQC very soon and a well-led inspection within six months of the request.

4.1.2 Care Quality Commission publishes report on Livewell Southwest

The CQC has published a report following an inspection at Livewell Southwest CIC, Plymouth. Inspectors visited the organisation between 3 September and 2 October. As a result Livewell Southwest is rated as Good overall as well as for whether its services are safe, effective, caring, responsive and well-led. When the service was previously inspected, in May 2018, it was rated as Good overall. It was rated Outstanding for being caring and rated Good for whether its services are safe, effective, responsive and well-led. Full details of the ratings, including a ratings grid, are given in the report published online at: https://www.cqc.org.uk/provider/1-271962340

5 Local Media Update

5.1 News release and campaigns highlights include:

- Regular information to the public on how best to be prepared if they need to access services and which ones will be best to meet their needs – Fine ways to stay out of hospital
- Promoting the various targeted HOPE Programmes
- A number of national awards including our Upper Gastrointestinal Surgical Team who work on diseases of the parts of the body involved in digestion
- Encouraging people including our staff to have flu jabs
- Celebrating our hard working staff over the festive period
- Communicating the value and our achievements in innovative research programmes
- Congratulations to all the dedicated staff that were awarded a Staff Hero Award
- One of our Torbay Hospital volunteers has been presented with a certificate in recognition of her support for military families over many years, especially by informally visiting former soldiers in hospital
- Health and Care job fayre with fantastic opportunities to work in health and care

6 Recommendation

Board members are asked to **receive and note** the report and **consider** any implications on the Trust's strategy and delivery plans.

Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 9 2019/20 (December 2019)			Meeting date: 5 February 2020
Report appendix	Month 9 Focus Report - review of month 9 metrics Appendix 1: Month 9 - Dashboard of IPR metrics		
Report sponsor	Director of Transformation and Partnerships Director of Finance		
Report author	Head of Performance		
Report provenance	Assurance and Transformation (16 January 2020) Executive Director scrutiny (21 January 2020) Information Governance Group (23 January 2020) Finance, Performance, and Digital Committee (28 January 2020)		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to bring together the key areas of delivery (including, quality and safety, workforce, operational performance, and finance) into a single integrated report to enable the Finance, Performance, and Digital Committee (FPDC) and Trust Board to: • take a view of overall delivery, against national and local standards and targets, at Trust and Integrated Service Unit (ISU) level; • consider risks and mitigations; • provide assurance to the Board that the Trust is on track to deliver the key milestones required by the regulator. Areas that the Board will want to focus on are highlighted below and detailed in the attached Focus Report.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to **review** the documents and note the evidence presented.		

Summary of key elements

Strategic objectives supported by this report	**Safe, quality care and best experience**	Yes	**Valuing our workforce**	Yes
	Improved wellbeing through partnership		**Well-led**	Yes
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework**	Yes	**Risk score**	
	Risk Register	Yes	**Risk score**	

External standards affected by this report and associated risks	

Care Quality Commission	Yes	**Terms of Authorisation**	
NHS Improvement	Yes	**Legislation**	
NHS England	Yes	**National policy/guidance**	Yes

This report reflects the following corporate risks:

- failure to achieve key performance standards;
- inability to recruit/retain staff in sufficient number/quality to maintain service provision;
- failure to achieve financial plan.

Report title: Integrated Performance Report (IPR): Month 9 2019/20 (December 2019)		**Meeting date:** 5 February 2020
Report sponsor	Director of Transformation and Partnerships Director of Finance	
Report author	Head of Performance	

Introduction

This report provides commentary against performance variances and improvements at the end of December (month 9) highlighted in the performance dashboard and supported by the focus report. This report describes mitigating action plans to deliver against agreed performance trajectories which have been reviewed through trust governance processes.

Discussion

Financial performance against 2019/20 plan

The financial performance as at 31st December 2019 (month 9) is a £10.14m deficit, which is £3.27m adverse to the phased plan of £6.87m deficit, prior to sustainability funding.

Although the position at month 9 showed a small positive variance (£352k) to forecast, it is expected that the year-end variance to control total will remain £15.0m.

At 31st December, the year to date capital expenditure is £7.14m and the full year forecast is £18.74m. Between now and the end of the year, it is expected that we will spend £11.6m for the following schemes: purchase of high value medical equipment £4.1m, continuation of Theatres upgrade and refurbishment of £3.3m, material investment in IT of £3.6m namely purchase of PC's and upgrade of Microsoft licenses and Torbay Pharmaceutical (TP) equipment lease of £0.6m.

The projected year end spend is based on the assessment of project scheme leads and this is reviewed on a monthly basis. Any change is reported to the NHSI and the Trust Board.

Performance: Against the national NHS I Single Oversight Framework

A&E patients seen within 4 hours: Rag rating **RED**

STF Trajectory (92%) not met - performance for December at 79.9%.

Referral to Treatment (RTT) – people waiting for treatment that have waited less than 18 weeks: Rag rating **RED**

RTT performance has seen little change in December with 79.4% of people waiting less than 18 weeks, behind the Operational Plan trajectory of 82%. Against 52 weeks we have seen a slight increase from 69 patients waiting last month to 71 patients this month; this is within our plan trajectory of 80 and then reduction to zero by end of March. The teams have highlighted a risk of 20 patients who may choose to wait longer than 52 weeks for their treatment at end of March 2020 and this has been discussed with regulators.

Cancer – 62 day wait for first treatment: Rag rating **GREEN**

National standard **met** in December with 85.4% against standard 95%.

Diagnostic tests longer than the 6 week standard: Rag rating **RED**

Trajectory is **not met** with 7.9% of patients waiting over 6 weeks. This is outside of our recovery trajectory to deliver improved performance in December to achieve 7.3% against the National standard of 1%.

Dementia Find: Rag rating **RED**

Standard is reported at 88.7%, therefore, **not achieving** the 90% standard**.**

Operational performance headlines:

Over the Christmas and New Year period the urgent care system has experienced continued pressure on critical staffing, bed occupancy, and care package capacity as can be seen in the increase across a number of metrics including:

- times spent in our emergency department;
- ambulance handover delays;
- corridor care,
- numbers of delayed discharges.

The increase in delayed discharges indicates the pressures across adult social care in providing timely assessment and packages or care. Maintaining workforce capacity through these extended holiday periods remains a challenge and highlights our reliance on temporary bank and agency staffing. A system response from the "silver reset" launched in December has been implemented and the daily review of all long stay patients has been successful in reducing the number of our longest ward stay patients.

Against elective care, the Trust remains confident on reducing the number of our longest waiting patients as outlined in this report against 52 weeks RTT and diagnostic tests as a result of additional investment in capacity solutions.

Across Adult Social Care we continue to manage the challenges and constraints of the market capacity to rapidly respond to variances in demand with a programme of improvement being delivered through the Adult Social Care Programme Board.

Workforce

In Month 9 we have seen a continued improvement in mandatory training and appraisal, however, our Registered General Nurse turnover rate has reached a two-year high at 13.6%.

Agency spend as at Month 9 is £2.205m above plan. Medical and Dental agency spend has decreased in recent months, however, is £1.651m over budget.

Quality

Detailed review of safety metrics is undertaken each month at the Quality Improvement Group and Quality Assurance Committee. The Month 9 metrics in the IPR are highlighting an increase on the number of patients with overdue outpatients follow up and that our fractured neck of femur quality standard for timely access to theatre within 36 hours is not being met.

Conclusion

This report highlights the areas of significant variance to plan and risk to meeting our performance and finance targets. The actions being taken are subject to review through our internal governance processes with oversight from executive leads. The board need to be assured that this report and governance process is providing sufficient evidence that risks are being identified and appropriate actions being taken.

Recommendations

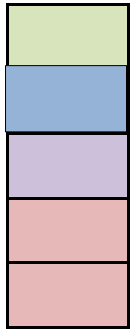
The Board are recommended to receive and note the information in this report and take appropriate action to manage identified risks.

NHS
Torbay and South Devon
NHS Foundation Trust

Integrated Performance Report

January 2020: Reporting period December 2019 (Month 9)

Section 1: PERFORMANCE



Quality Focus

Workforce Focus

Community and Social Care Focus

NHSI operational performance indicator focus

Local performance metric exception

Section 2: FINANCE

Finance Focus

Quality Focus

Month 9 (performance to end of December 2019)

Page 3	Quality and Safety Summary
Page 4	Mortality
Page 5	Infection Control
Page 6	Incident Reporting and Complaints
Page 7	Exception Reporting

Quality and Safety Summary

Quality and Safety Summary December 2019

There are 21 Local Quality Framework indicators in total of which 3 were RAG rated RED for December (4 RED in November) as follows in table below:

Standard	Target	Last month Month 8	This month Month 9
VTE – risk assessment on admission (acute)	>95%	93.2%	91.7%
Fractured Neck of Femur	>90%	73%	Not available
Follow ups past to be seen date (excluding Audiology)	3,500	6725	7243

* **Fractured neck of femur** data for the % of cases into theatre within 36 hours is not available this month due to late data entry.

VTE continues to be under target - Resources on wards to support consistent recording from paper notes into our electronic reporting systems remain a challenge.
The "safety thermometer" audits which look at all notes on a single day in the month confirm that actual assessment performance is being maintained at over 94.%, just below the target of 95%.

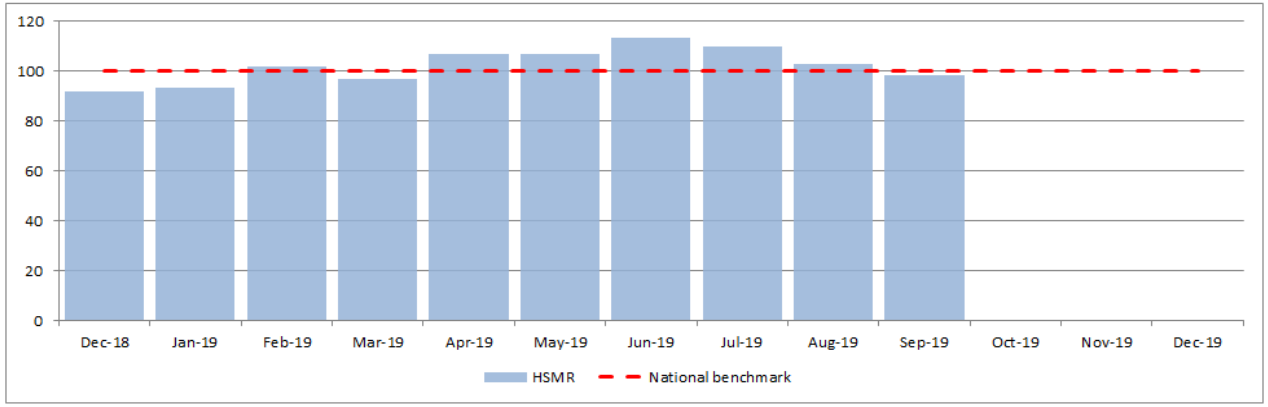
Fractured Neck of Femur - staff vacancies has contributed to a backlog in recording the data - this is being escalated with teh team. The performance remains below the required standard and has been escalated to teh surgical teams to report back on the required actions needed to improve this performance. Theatre capacity contraints over the last 12 months has been a challenge however with our reopening of theatres in Q3 it is expected that this performance will improve.

Follow Ups - The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' increased in December to 7243.
The Quality Assurance Group maintain oversight and assurance regarding any harm to patients and review plans to mitigate clinical risk against patients waiting beyond their intended review date.

Quality and Safety - Mortality

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

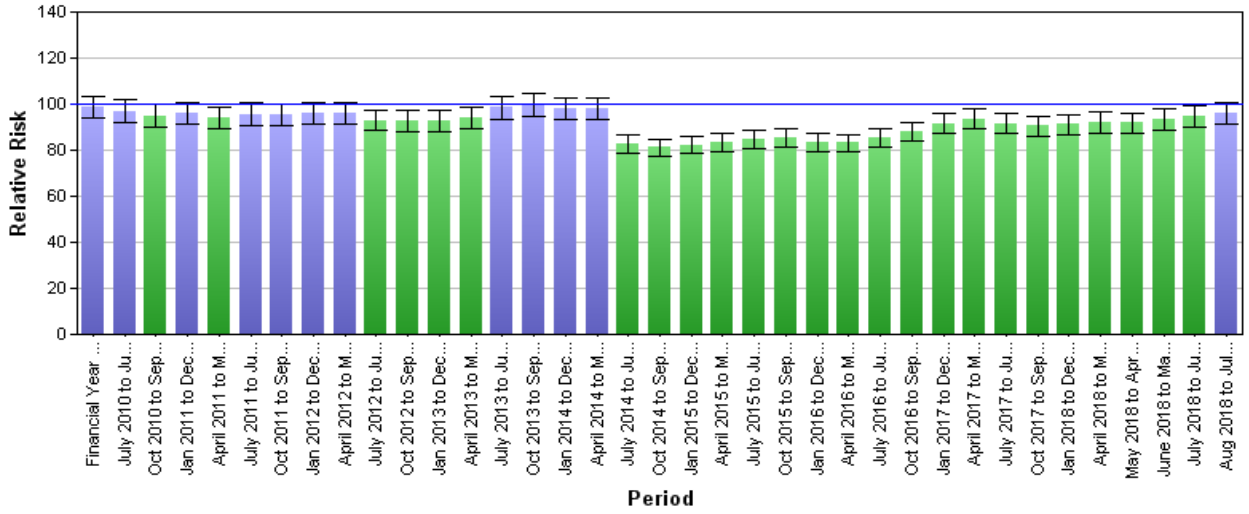
	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
HSMR	91.8	93.2	102	96.7	106.8	106.7	113.6	109.9	103.1	98.4	n/a	n/a	n/a
National benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



Trust wide mortality is reviewed via a number of different metrics, however, Dr Foster allows for a standardised rate to be created for each hospital and, therefore, this is a hospital only metric. This rate is based on a number of different factors to create an expected number of monthly deaths and this is then compared to the actual number to create a standardised rate. This rate can then be compared to the English average, the 100 line. Dr Foster's mortality rate runs roughly **three month in arrears**.

The latest data for Dr Foster HSMR is showing a relative risk of 98.4.

SHMI by data period



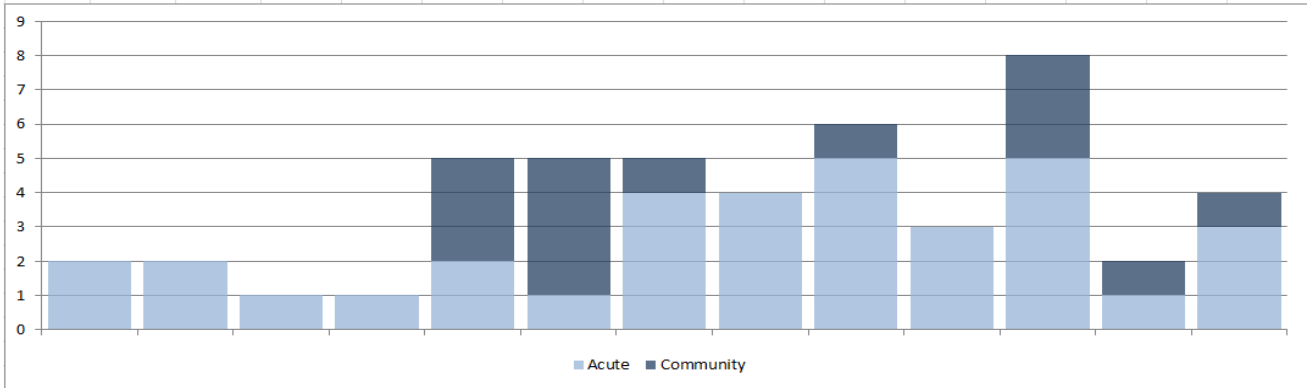
The Summary Hospital Mortality Index (SHMI) data reflects all deaths recorded either in hospital or within 30 days of discharge from hospital and records the Trusts at 90.58 against a national average benchmark of 100. Latest data for period August 2018 –to July 2019.
SHMI, HSMR, and Dr Foster alerts are reviewed through the Mortality Surveillance Scorecard at the Quality Improvement Group.

A score of 100 represents the weighted population average benchmark.

Quality and Safety - Infection Control

Number of Clostridium Difficile cases

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Acute	2	2	1	1	2	1	4	4	5	3	5	1	3
Community	0	0	0	0	3	4	1	0	1	0	3	1	1

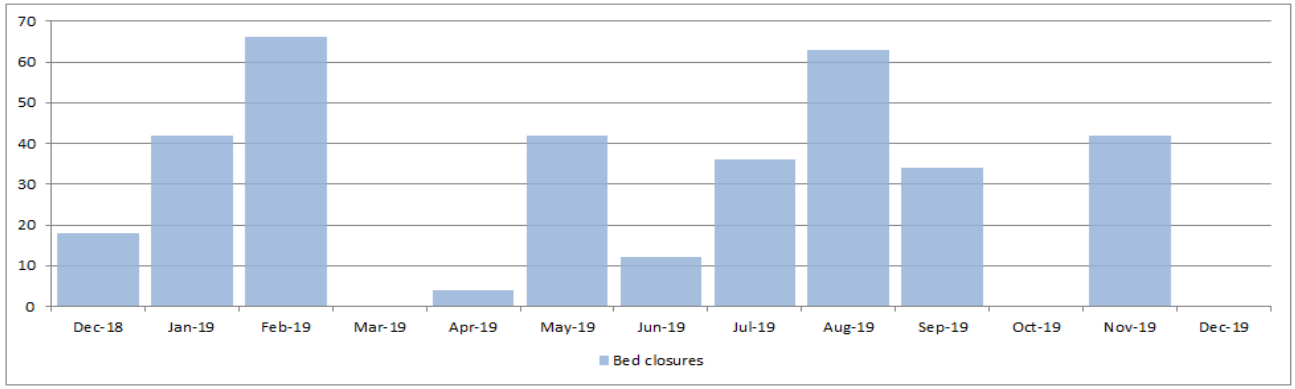


The cumulative total is 38 cases with 25 in the acute hospital and 13 in the community.

Each reported case of C-diff undergoes a Root Cause Analysis; learning from these is used to inform feedback to teams and review of systems and processes.

Infection control - Bed closures (Acute)

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Bed closures	18	42	66	0	4	42	12	36	63	34	0	42	0



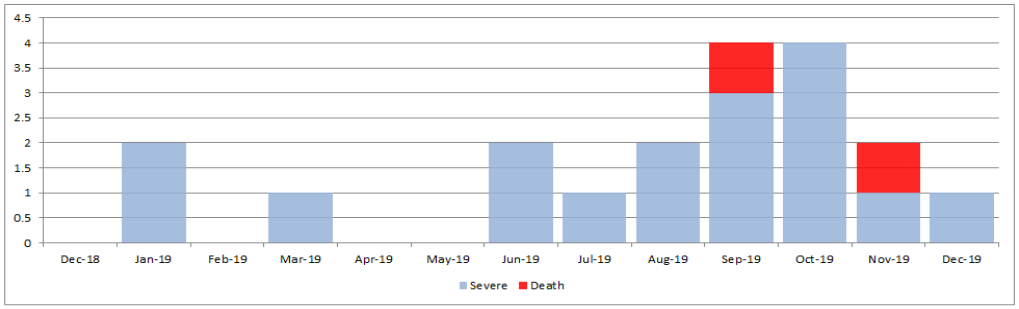
The Infection Control Team continue to manage all cases of outbreaks with individual case by case assessment and control plans.

In December, there were no bed days lost due to infection control issues.

Quality and Safety - Incident reporting and complaints

Reported Incidents - Severe and Death

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Severe	0	2	0	1	0	0	2	1	2	3	4	1	1
Death	0	0	0	0	0	0	0	0	0	1	0	1	0

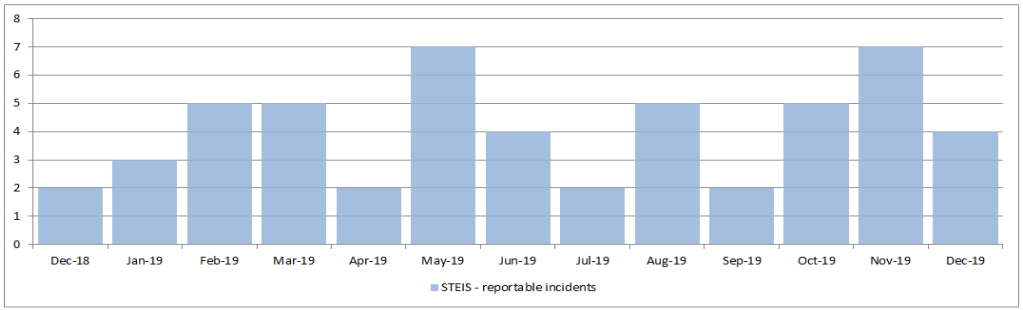


In December the Trust recorded one incident which will follow the normal process of investigation; the sites of the incident was in Urology.

Please note the severity of an incident may change once fully investigated.
The Learning and Sharing from Serious Adverse Events Group meet once a month to review serious incidents and seeks assurance on actions for ISUs. The group also, where necessary, instigates Trust wide learning.

STEIS Reportable Incidents

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
STEIS - reportable incidents	2	3	5	5	2	7	4	2	5	2	5	7	4



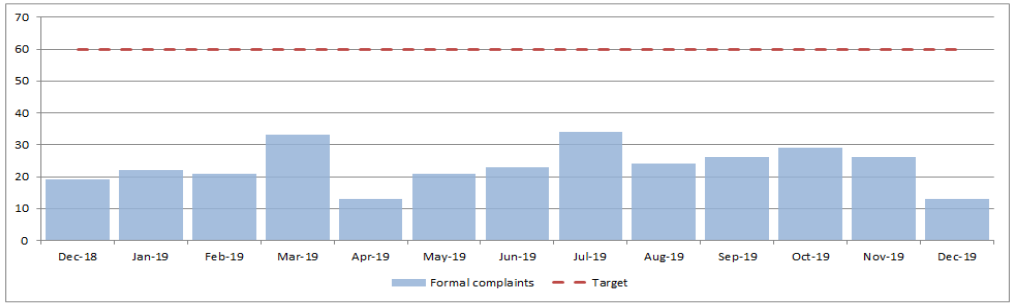
The Trust reported four incidents in December on the Strategic Executive Information System (StEIS).
The sites of recorded incidents are:

1. Totnes Hospital
2. Midgley Ward
3. Allerton Ward
4. Delivery Suite

All incidents are being investigated for learning and sharing and have followed the Duty of Candour process .

Formal complaints

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Formal complaints	19	22	21	33	13	21	23	34	24	26	29	26	13
Target	60	60	60	60	60	60	60	60	60	60	60	60	60



In December the Trust received 13 formal complaints.

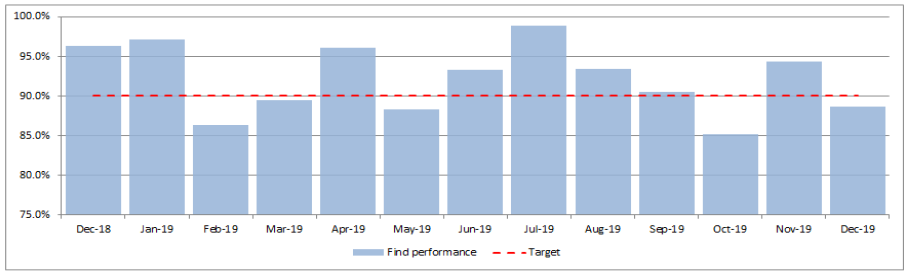
The main themes from the complainants are assessment, care, and treatment.

All complaints are investigated locally and shared with area/locality for learning.

Quality and Safety - Exception Reporting

Dementia - Find

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Numerator	365	377	328	390	390	348	429	426	381	362	378	447	470
Denominator	379	388	380	436	406	394	460	431	408	400	444	474	530
Find performance	96.3%	97.2%	86.3%	89.4%	96.1%	88.3%	93.3%	98.8%	93.4%	90.5%	85.1%	94.3%	88.7%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

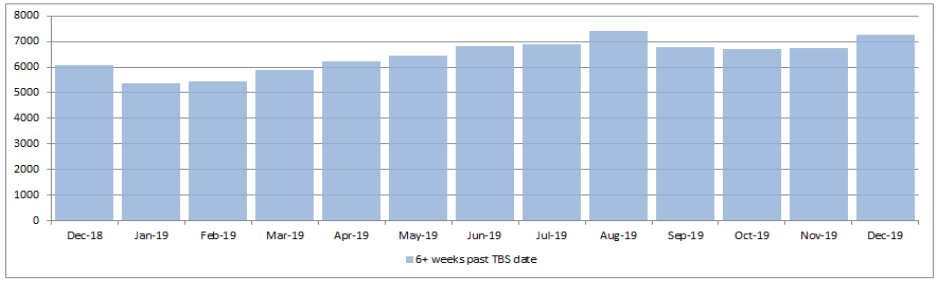


Dementia Find: The NHS I Single Oversight Framework (SOF) includes Dementia screening and referral as one of the NHSI priority indictors.

The Trust has not achieved the Dementia Find standard in December with 88.7% against the target of 90%.

Follow ups 6 weeks past to be seen by date

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
6+ weeks past TBS date	6062	5378	5437	5899	6240	6459	6803	6906	7393	6793	6694	6725	7243

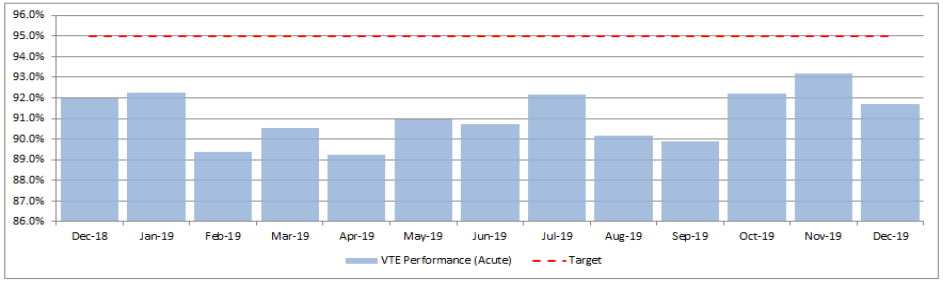


Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' increased in December to 7243.

The Quality Assurance Group maintain oversight and assurance regarding any harm to patients and review plans to mitigate clinical risk against patients waiting beyond their intended review date.

VTE risk assessment on admission - (Acute)

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
VTE Numerator	5275	6045	5116	5557	5488	6001	5568	5936	5792	5487	6196	6129	5743
VTE Denominator	5735	6554	5725	6138	6151	6597	6137	6441	6425	6104	6721	6577	6262
VTE Performance (Acute)	92.0%	92.2%	89.4%	90.5%	89.2%	91.0%	90.7%	92.2%	90.1%	89.9%	92.2%	93.2%	91.7%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



VTE: VTE performance in December and remains below the standard of 95% at 91.7%. Resources on wards to support consistent recording into reporting systems remain a challenge.

The "safety thermometer" audits which look at all notes on a single day in the month confirm that actual assessment performance is being maintained at 94.7%, just below the target of 95%.

Workforce Focus

Month 9 (performance to end of December 2019)

Page 9	Workforce summary
Page 10	Workforce WTE
Page 11	Sickness absence
Page 12	Turnover
Page 13	Appraisal and Training
Page 14	Agency

Workforce Summary

Of the four workforce KPIs on the IPR dashboard two are RAG rated Green, two RAG rated Red as follows:

Turnover (excluding Junior Doctors): **GREEN**
The Trust's turnover rate now stands at 11.4% for the year to December 2019, demonstrating no change from November.

Staff sickness/absence: RED
The annual rolling sickness absence rate was 4.39% at the end of November 2019. This is against the target rate for sickness of 4%. The Monthly sickness figure for November was 4.84 % which is a reduction from the 4.84% as at the end of October. The Workforce and OD directorate are actively working with departments to ensure that absence is robustly managed. In addition a variety of wellbeing events are being arranged to support staff with their health and wellbeing.

Mandatory Training rate: **GREEN**
The current rate is 90.44% for December 2019 against a target of 90%.

Appraisal rate: **RED**
The Achievement Review rate for the end of December 2019 was 78.52% which is an increase from 77.99% as at the end of November. A deep dive is being currently being undertaken to identify hotspots, development of improvement plans and identifying areas of good practice.

In addition to the workforce KPIs there are two further workforce indicators that are being tracked to provide assurance to the Board

Workforce Plan – As at end of November 19 the variance of substantive workforce worked was 59.8 wte below budget.

Agency Expenditure – As at Month 9 the Trust is £2.205m above plan. This is predominantly due to agency spending on Medical and Dental staff which is £1.651m over budget. However Medical and Dental agency spend is decreased, a number of actions have been taken to support this reduction including; regular review of current and future bookings by Deputy Medical Director and conversion of agency workers to bank.

Workforce - WTE

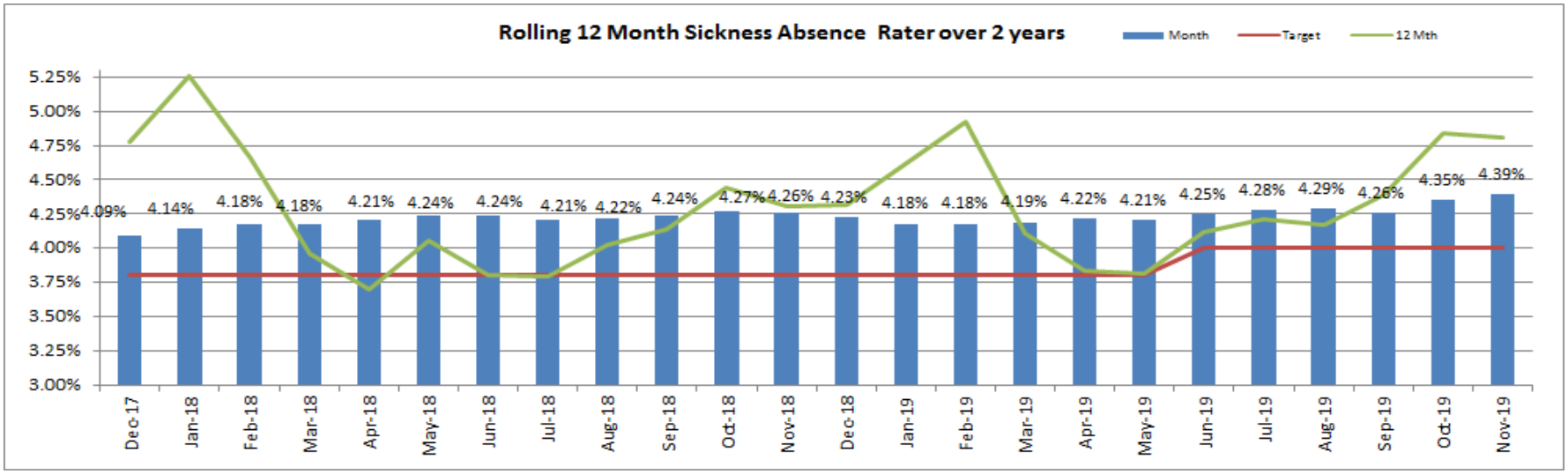
FTE Staff in Post (NHSI staff Groups from ESR month end data)

NHSI Staff Grp	2015/09	2016/09	2017/09	2018/09	2019/09	2019/12	Change since ICO	% Change
Allied Health Professionals	420.56	411.16	401.50	408.83	486.15	482.05	61.49	14.62%
Health Care Scientists	89.69	92.75	92.13	91.28	90.91	92.41	2.72	3.03%
Medical and Dental	425.99	437.61	497.69	505.21	535.17	512.85	86.86	20.39%
NHS Infrastructure Support	1114.22	1099.87	1006.29	1004.70	1083.45	1072.92	-41.30	-3.71%
Other Scientific, Therapeutic and Technical Staff	301.99	309.19	350.35	356.62	365.33	374.59	72.60	24.04%
Qualified Ambulance Service Staff	1.00	4.00	5.60	6.72	7.59	6.72	5.72	572.00%
Registered Nursing, Midwifery and Health visiting staff	1187.78	1193.74	1169.78	1166.50	1204.15	1187.20	-0.58	-0.05%
Support to clinical staff	1593.74	1656.67	1613.65	1691.26	1807.54	1811.45	217.72	13.66%
Grand Total	5134.99	5204.99	5136.99	5231.12	5580.29	5540.20	405.21	7.89%

This information is reviewed at the People Committee, a sub-committee of the Trust Board.

Workforce - Sickness Absence

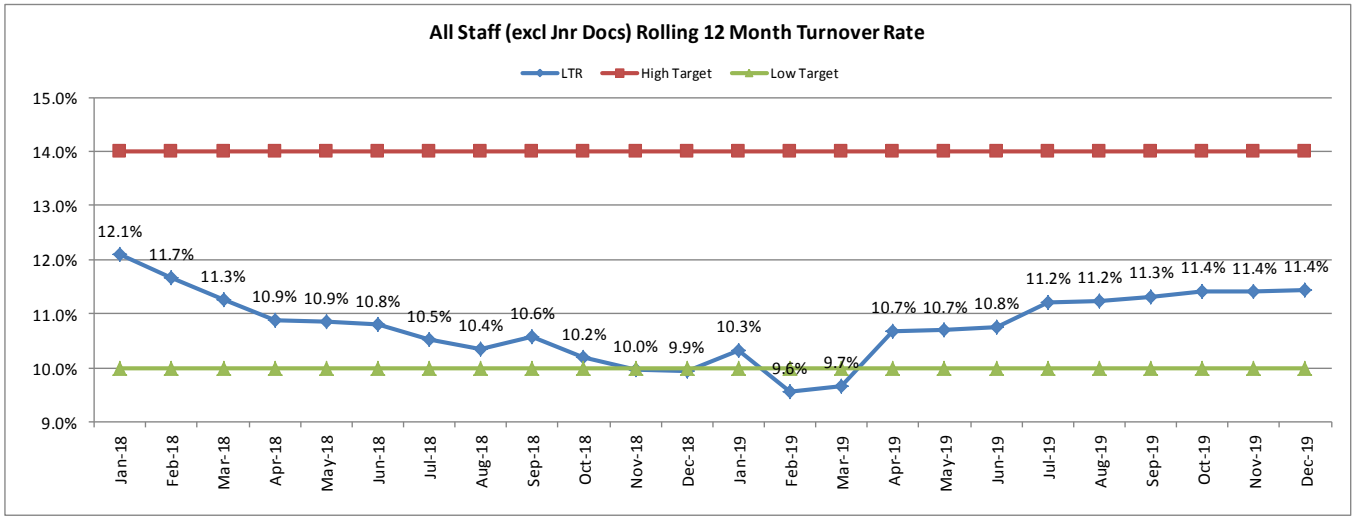
Rolling 12 month sickness absence rate - (reported one month in arrears)



The annual rolling sickness absence rate was 4.39% at the end of November 2019 which is an increase from October which stood at 4.35%

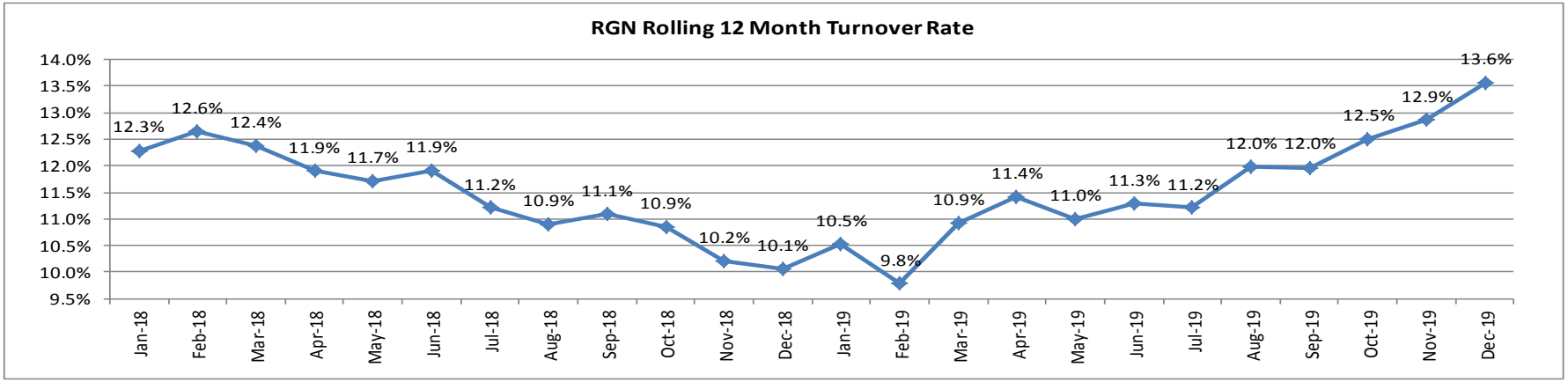
The Monthly sickness figure for November was 4.81 % which is a slight reduction from the 4.84% as at the end of October.

Workforce - Turnover



The graph shows that the Trusts turnover rate now stands at 11.42% for the year to October 2019 which is a slight increase from 11.32% in September.

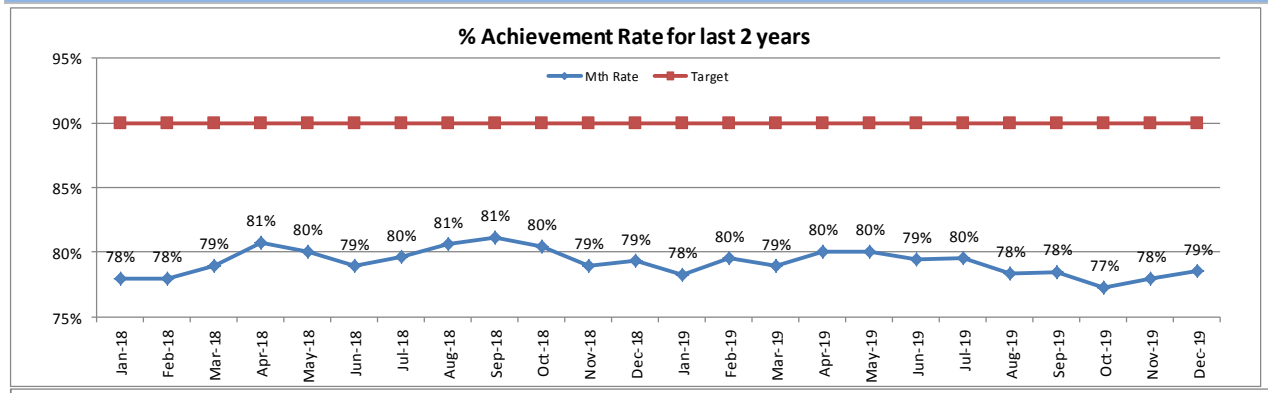
There could be an increase in the turnover figure next month when the recent MARS leavers are taken into account on top of the standard turnover.
The recruitment challenge to replace leavers from key staff groups remains significant.



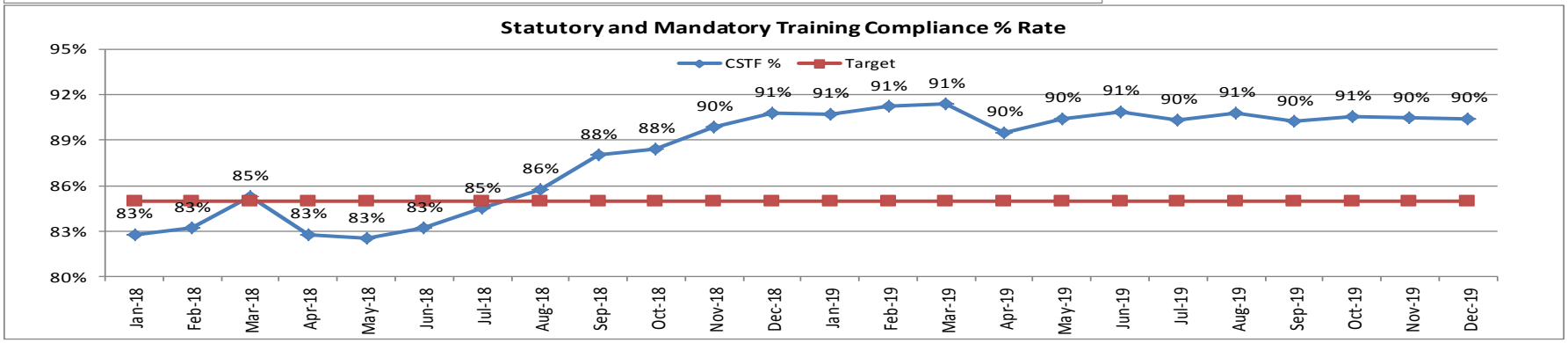
RGN Rolling 12 Month Turnover Rate

This recruitment challenge includes Registered Nurses due to the supply shortage as reported elsewhere and for which the Trust has a long term capacity plan to address, which maximises the use of all supply routes including overseas recruitment, return to nursing, growing our own etc.
The turnover rate for this staff group is within the range of 10% to 14% and for the 12 months ending in December 2019 stood at 13.56% which is again higher than the previous month of November which stood at 12.86%. In the last 3 months 37.21 FTE have left and only 14.49 FTE have started however a small number of Overseas Nurses have now commenced employment and upon reaching all the relevant criteria will then become qualified Nursing and Midwifery staff.

Workforce - Appraisal and Training



Achievement Review (Appraisal)
The Achievement Review rate for the end of December was 78.52% which is an increase from 77.99% as at the end of November and now includes Medical and Dental staff. Managers are provided with detailed information on performance against the target on a monthly basis.



Statutory and mandatory training - The Trust has set a target of 85% compliance as an average for the statutory and mandatory training modules which is against the 11 subjects which align with the Mandatory and Statutory Training (MAST) Streamlining project from April 2018. The graph shows that the current rate is 90.44% for December which is a minor change from the 90.45% in November.
Individual modules that remain below their target are detailed in the table below and also included are the specific levels for Safeguarding:

Safeguarding Adults Compliance

Dec-19				
Level 1	Level 2	Level 3 &	Level 5	Level 6
6517	4007	540	42	6
6301	3525	458	34	3
96.69%	87.97%	84.81%	80.95%	50.00%

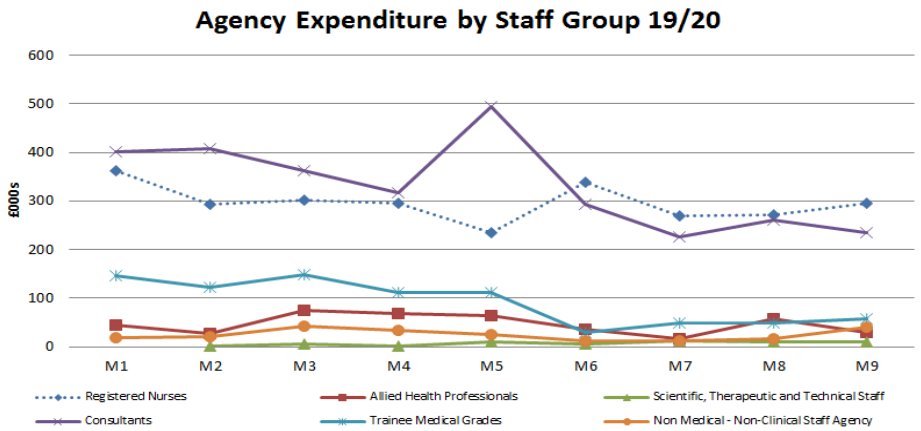
Safeguarding Children Compliance

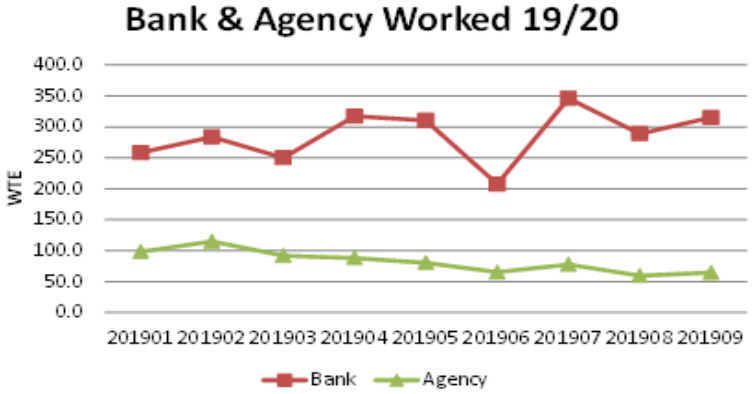
Dec-19		
Level 1	Level 2	Level 3
2487	3365	665
2355	2788	502
94.69%	82.85%	75.49%

Module	Target	Performance
Information Governance	95% and above	85.76%
Infection Control	85% and above	84.87%

Workforce - Agency Expenditure

The graph below shows the agency expenditure by staff Group, whilst the table provides the detailed analysis. As at Month 9 the Trust is £1.660m above plan. This is predominently due to agency spend on Medical and Dental staff which is £2.205m above plan, although there is a downward trend for medical





Torbay and South Devon NHS Foundation Trust
Total Agency Spend
Financial Year 2019/20

	Monthly Values									NHSI YTD value (Cumulative)								
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M1	M2	M3	M4	M5	M6	M7	M8	M9
Plan - Total Agency (see breakdown below)	636	636	636	633	633	633	385	385	404	636	1,272	1,908	2,541	3,174	3,807	4,192	4,577	4,981
Actual Spend																		
Non-Medical - Clinical Staff Agency																		
Registered Nurses	363	293	303	295	235	338	269	272	296	363	656	959	1,254	1,489	1,827	2,096	2,368	2,664
Scientific, Therapeutic and Technical	45	29	80	70	74	41	29	66	39	45	74	154	224	298	339	368	434	473
of which Allied Health Professionals	45	28	75	69	64	36	16	57	30	45	73	148	217	281	317	333	390	420
of which Other Scientific, Therapeutic and Technical Staff		1	5	1	10	5	13	9	9	0	1	6	7	17	22	35	44	53
Support to clinical staff (HCA)	1	-1		0					1	1	-	-	-	-	-		0	1
Total Non-Medical - Clinical Staff Agency	409	321	383	365	309	379	298	338	336	409	730	1113	1478	1787	2166	2464	2802	3138
Medical and Dental Agency															0			
Consultants	401	409	363	317	495	293	227	261	234	401	810	1,173	1,490	1,985	2,278	2,505	2,766	3,000
Trainee Grades	146	122	149	111	112	29	48	50	58	146	268	417	528	640	669	717	767	825
Total Medical and Dental Agency	547	531	512	428	607	322	275	311	292	547	1078	1590	2018	2625	2947	3222	3533	3825
Non Medical - Non-Clinical Staff Agency	19	20	43	34	25	13	12	17	40	19	39	82	116	141	154	166	183	223
Total Pay Bill Agency and Contract	975	872	938	827	941	714	585	666	668	975	1847	2785	3612	4553	5267	5852	6518	7186
Over (Under) Spend	339	236	302	194	308	81	200	281	264	339	575							

Community and Social Care Focus

Month 9 (performance to end of December 2019)

Page 16 Community and Social Care Summary
Page 17 Social Care and Public Health Metrics
- Torbay LA social care programme board metrics
- Public health metrics including CAMHS

Page 18 Community services
- Community Hospitals
- Community services
- Intermediate care services
- Delayed Transfers of care

Community and Social Care Summary

There are 15 Community and Social Care indicators in total of which 5 were RAG rated RED in December (5 in November 2019) as follows:

Standard	Target	Last month Month 8	This month Month 9
Delayed discharges (Community)	16/16 Avg 315	319	344
Timeliness of Adult Social Care Assessment assessed within 28 days of referral	>70%	68.9%	68.8%
Clients receiving Self Directed Care	>90%	89%	89.1%
Bed occupancy (overall system)	80%-90%	97.6%	98.6%
Community Hospitals – admissions (non-stroke)	18/19 profile +/- 10%)	230	212

Social Care and Public Health Metrics performance metrics - Torbay

Torbay Social Care KPIs	2019/20 full year target	2019/20 YTD target	Outturn YTD	Comment
% clients receiving self-directed support	94%	94%	89% (94%)	Below target (1463 / 1642). Just below threshold for green rating.
% clients receiving direct payments	28%	28%	25.2% (28.0%)	Below target (414 / 1642). CLS workstream 2 expected to improve performance by developing DP policy, process & training. Deputy DASS to join working group as sponsor.
% clients receiving a review within 18 months	93%	93%	81% (93%)	Below target (2313 / 2858). Decreasing trend.
Timeliness of social care assessment	80%	80%	69% (80%)	Below target (759 / 1103). Step decrease in Aug19 following calculation changes highlighted by internal audit.
Permanent admissions (18-64) to care homes per 100k population (rolling 12 month)	14.0	14.0	21.5 (14)	A low outturn signifies better performance. Below target (16 admissions).
Outcome of short term support - % reablement episodes not followed by long term SC support	83%	83%	84.3% (83%)	On target.
Carers receiving needs assessment, review, information, advice, etc.	36%	36%	35.4% (27.0%)	On target.
% carers receiving self directed support	85%	85%	92% (85%)	On target.
% of high risk adult safeguarding concerns where immediate action was taken to safeguard the individual	100%	100%	.. ..	No high risk concerns raised.
% Repeat safeguarding referrals in last 12 months	8.0%	8.0%	8.5% (8.0%)	A low outturn signifies better performance. Below target. A recent audit was undertaken which did not identify any significant reason for the slight increase. Repeat referrals often link to care service enquiries or repeat referrals for those that do not consent to action by the local authority.
% Adults with learning disabilities in paid employment	7.0%	7.0%	9.0% (7.0%)	On target.
% Adults with learning disabilities in settled accommodation	80%	80%	79.4% (80.0%)	Within agreed tolerance.

The Social Care and Public Health metrics above relate to the Torbay LA commissioned services. Comments against indicators are shown in the dashboard. The metrics and exceptions are reviewed at the Torbay Social Care Programme Board (SCPB), monthly ISU system leadership Assurance and Transformation meetings .

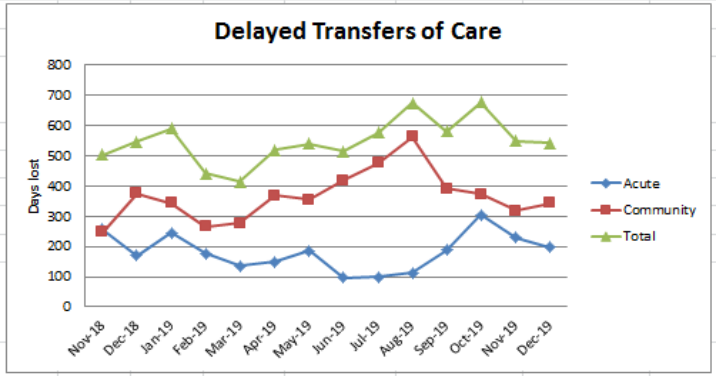
Corporate Objective	Measure	Target 2019/2020	13 month trend	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Year to date 2019/20
PUBLIC HEALTH SERVICES																	
	CAMHS - % Urgent referrals seen within 1 week	88.0%		50.0%	100.0%	75.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	50.0%	75.0%	75.0%	81.8%
	CAMHS - % patients waiting under 18 weeks at month end [B]	92.0%		93.7%	89.4%	90.8%	90.3%	87.6%	83.9%	82.6%	83.1%	86.0%	91.6%	91.6%	92.4%	91.6%	88.0%
	% of face to face new birth visits within 14 days *	95.0%		90.9%	92.2%	90.9%	93.8%	88.6%	96.8%	93.0%	91.7%	91.5%	90.4%	96.0%	94.4%	96.4%	93.1%
	Children with a child protection plan * [B]			172	170	186	183	170	186	201	228	219	206	184	176		176
	4 week smoking quitters (Quarterly) ** [B]	200		192			300			54			109				109
	Opiate users - % successful completions of treatment (Quarterly) ** [B]			5.4%			4.9%			5.6%			5.3%				5.3%

Public Health Torbay : The headline messages for Public Health performance are:
CAMHS - Target Referral to Treatment (18 week) waiting times are not achieved in December. Since April Torbay CAMHS is part of the wider Devon Children's services alliance. Work is progressing to integrate reporting for the new combined services and are reviewed through the Alliance board.
Quarterly data is shown in arrears for smoking, opiate users, and children with a protection plan.

Community Services and Social Care metrics

Community Hospital Dashboard - Summary of Key Measures - December-19

	Act. 18/19 Outturn	19/20 Year End Target	Target Dec-19	Dec-19	Total	YTD Target	Cum. Direction of Travel
Admissions / Discharges							
Total Admissions (General)	2,927	2,927	236	212	1,997	2,169	↓
Direct Admissions (General)	294	294	26	17	200	214	↓
Transfer Admissions (General)	2,633	2,633	210	195	1,797	1,955	↓
Stroke Admissions	305	305	21	22	188	231	↓
Transfers from CH to DGH	242	242	16	18	178	182	↓
Beds							
Bed Occupancy [1]	91.6%	90.0%	90%	98.6%	94.7%	90.0%	
Bed Days Lost to Delays [2]	3,305	0	0	344	3,643	0	
Bed Days Lost to Bed Closure	329			0	41		
Length of Stay							
Delayed Discharges				41	405		
Average Length of Stay - Overall (General)	10.9			13.1	12.7		
Average Length of Stay - Direct Admissions	8.1	8.5	8.5	10.2	10.6	8.5	↑
Average Length of Stay - Transfer Admissions	11.3	11.5	11.5	13.4	13.0	11.5	→
Average Length of Stay - Stroke	15.2	0.0	0.0	17.0	18.1	18.0	→
Long LoS (>30 days)	171	171	14	22	171	120	↑
MIUs							
Total MIU Activity [3]	41,788	41,788	2,769	3,216	33,179		
New MIU Attendances	36,179	36,179	2,375	2,882	29,642	28,213	↑
All Follow Up Attendances	5,609	5,609	134	334	3,537	4,497	↓
Planned Follow Up Attendances	4,382	4,382	274	250	2,578	3,556	↓
Unplanned Follow Up Attendances	1,227	1,227	120	84	959	941	→
MIU Four Hour Breaches	5	5	1	0	3	4	
Average Waiting Time (Mins) - 95th Pctile	49	49	49	50	53	49	↑



The Community Hospital Dashboard highlights

Bed occupancy remains above planned levels to maintain capacity to respond to escalation pressures with average length of stay of 12.7 days from an average last year of 10.9 days

Minor injury Units

In December no patients were recorded as having waited over 4 hours to be seen and treated.

Transfers of Care (DToC)- The number of bed days reported as lost to delayed transfers of care increased in December. There remain concerns that the number of patients being categorised as medical fit on our wards is increasing and not fully reflected in reported delays. A review of process has been completed resulting in a roll out of revised standard operating procedure overseen by the Moor to Sea ISU. As part of the urgent care improvement work teams are focussing on weekend discharges.

Community based services highlights:

Nursing Community nursing and community outpatient activity targets are being reviewed through the productivity work currently underway. The latest month can show a lower level of activity to plan due to data entry lag.

Intermediate care urgent referrals There remains variation on rates of referral across different Integrated Service Units and this is being picked up through the locality review / Enhanced Intermediate Care meetings. Through the Community Productivity Programme there is a continued focus on the quality and consistency of data recording.

Intermediate Care (IC) placements The year to date average length of stay in IC placements remains above target (12 days). There remains variation between different zones in the utilisation of IC and the percentage of referrals that convert to placement, this is being reviewed as part of the wider ICO evaluation and productivity

Measure	Target 2019/2020	13 month trend	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Year to date 2019/20
COMMUNITY BASED SERVICES																
Nursing activity (F2F)			16,370	16,906	15,122	15,029	16,202	17,437	15,729	16,633	14,576	13,292	13,605	12,095	10,345	129,914
Therapy activity	65,415		4,802	5,373	5,180	4,717	5,122	5,249	5,144	6,660	5,608	6,166	6,521	5,751	4,876	51,097
No. intermediate care urgent referrals [B]	2,059		157	189	156	164	184	189	179	188	173	178	216	205	195	1,707
No. intermediate care placements			77	96	83	73	75	69	86	76	73	63	61	60	50	613
Intermediate Care - placement average LoS [B]	12.0		15.4	18.1	13.6	18.7	18.9	18.2	15.6	17.3	16.9	18.5	20.8	16.1	18.3	17.8

Operational Performance Focus

Month 9 (performance to end of December 2019)

Page 20	NHSI indicators performance summary
Page 21	Referral to Treatment
Page 22	4-hour Standard for time spent in the Emergency Department and Minor Injuries Units
Page 23	Cancer treatment and cancer access standards
Page 24	Patients waiting over six weeks for diagnostics
Page 25	Other performance exceptions

NHS I Performance indicator Summary

NHSI Single Oversight Framework Performance Standards

NHSI Indicator	National Standard	Trajectory (M09):	ICO Performance (M09):	Risk
Patients seen within 4 hours in A&E	>95%	92%	79.9% ↑	HIGH
Risks identified: Continued high level of escalation with delays attributed to availability of inpatient beds and crowding in ED. Presentations of Flu and infection have been seen but not above expected levels. Facilitating the daily availability of assessment beds on EAU3 remains the key to delivering capacity. The Silver reset initiative implemented in December has seen improvement across several key metrics to deliver earlier discharge and presentation to ED from SWAST.	**Management action:** The Urgent Care Programme Board meeting every 2 weeks oversees the improvement programme to provide senior clinical and operational decisions to support escalated actions. System reset commenced with positive impact coupled with the communication and launch of the Winter Plan. An escalation process has been agreed with the CCG. Winter funding to support local plan to support surgical assessment area being finalised. This will release capacity for medical assessment on EAU3 and both actions will reduce overcrowding within ED. Executive escalation of discharge process over 7 days.			
Patients waiting longer than 18 weeks from referral to treatment	>92%	82%	79.4% ↓	HIGH
Risks identified: We continue to see increases in the number of patients waiting for new outpatient appointment and day case treatments. This is a driver for the overall increasing number of incomplete pathways. The trajectory of zero over 52 week patients is a High Risk of not being met. We have maintained our position of being outside of the bottom 20 trusts that includes our neighbouring providers demonstrating the reginal pressures on managing elective waiting times.	**Management action:** RTT Risk and Assurance meets to review progress against delivery and risk. We are working with the STP to identify patients suitable for outsourcing. Saturday lists will continue to run to the end of March 2020 to support in house capacity for T&O, Urology, and UGI with continued in-sourcing to support Ophthalmology and Gastro. The additional insourcing is needed to deliver the trajectory and remains high risk of not being met. The COO is leading on escalating the necessary arrangements to allow this to be delivered. It is noted that potentially 20 patients may remain untreated within 52 weeks due to patient choice.			
Cancer – 62 day wait for first treatment for a 2 week wait referral	85%	85.5%	85.4% ↑	HIGH
Risks identified: Delays to diagnosis in Urology pathways remains a risk and greatest potential for improvement for the delivery of this standard.	**Management action:** Delays to the Urology pathway for diagnosis will be supported in Q4 with a prostate biopsy second machine and couch now ordered. This will deliver increased capacity for local anaesthetic and theatre based biopsies. Other elements of the capacity to support target delivery are in place.			
Diagnostic tests longer than 6 weeks	1%	7.33%	7.9% ↓	HIGH
Risks identified: Good progress has been seen in reducing waits in particular in both CT and MRI supported by the continued use of mobile van. Waits for Colonoscopy are now stabilising with capacity from additional in-sourcing weekends and new consultant now commenced in post. Plans to deliver in-house CT and MR capacity continue to be worked on.	**Management action:** Maintaining mobile van capacity in Radiology and frequency of insourcing for Colonoscopy continue to support the interim plan for managing these waits. We have been successful in our bid for additional funding to deliver additional activity for colonoscopy and with these plans can give a high level of assurance of meeting the end of year agreed trajectory of performance improvement.			
NHS I indicator: **Dementia Find**	90%	90%	88.7% ↓	LOW

Colour of arrow – current Red/Amber/Green rating against trajectory
Arrow – improved, declined, or remained static from previous month

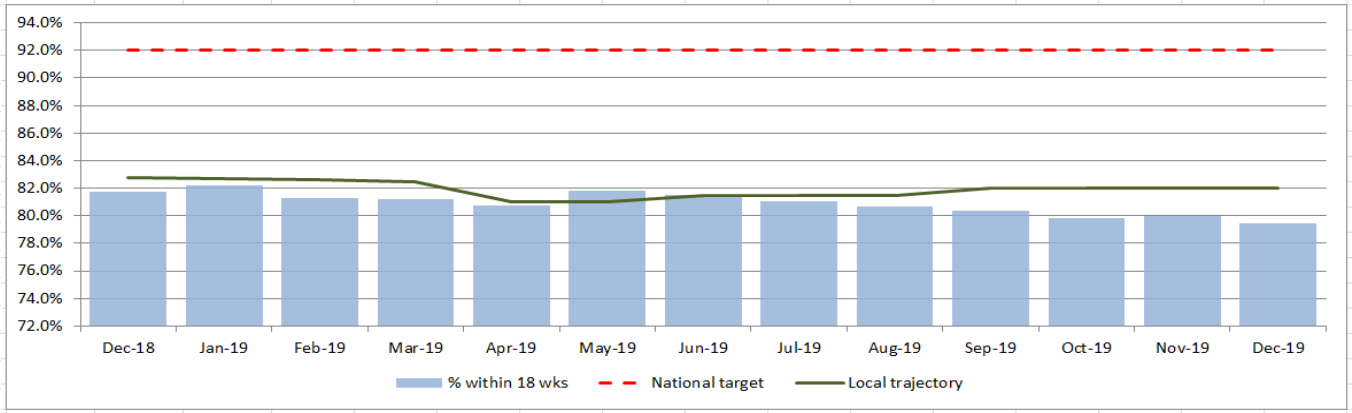
NHSI Indicator - Referral to Treatment

Services with greater than 100 patients waiting over 18 weeks

December 2019 Incomplete 92% Table National Specialty

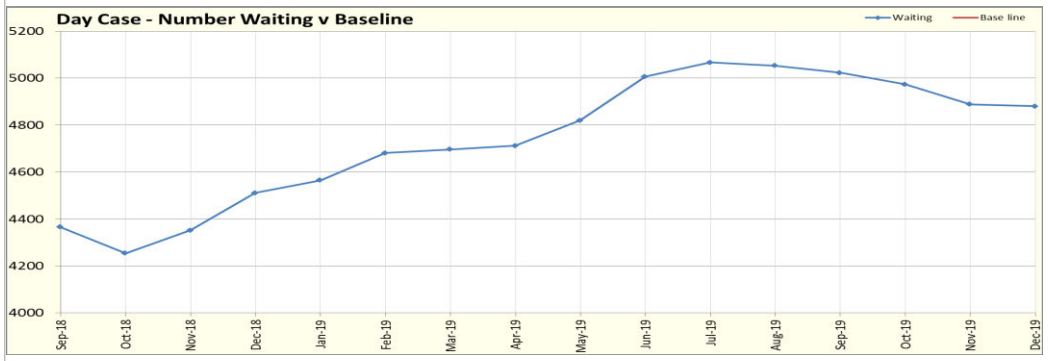
Submitted Spec	Incomplete IPDC	Incomplete Outpatients	Grand Total	% < 18wk
Plastic Surgery	106		309	65.70
Orthodontics		113	208	45.67
Paediatrics	1	134	1006	86.58
Dermatology		136	1019	86.65
Neurology	5	142	620	76.29
Gastroenterology	76	101	1439	87.70
ENT	40	169	1483	85.91
Cardiology	33	285	1746	81.79
Urology	218	172	1359	71.30
Upper Gastrointestinal Surgery	299	116	784	47.07
Trauma & Orthopaedics	438	186	2211	71.78
Ophthalmology	685	80	2526	69.71
Grand Total	**2095**	**1994**	**20391**	**79.95**

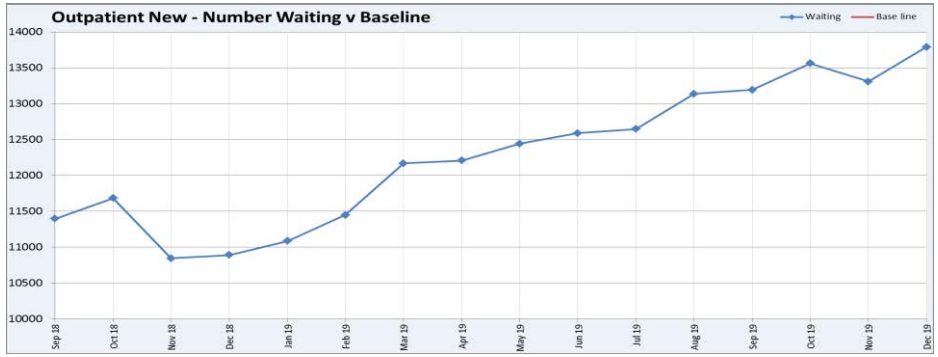
Referral to Treatment - Incomplete pathways



Referral to Treatment - RTT: RTT performance has not changed in December with the proportion of people waiting less than 18 weeks at **79.95%** this is behind the Operational Plan trajectory of 82% and national standard of 92%. The total number of incomplete pathways (waiting for treatment) has risen to 20,391, an increase of 333 from November and above our revised trajectory.
52 week waits : For December, 71 people will be reported as waiting over 52 weeks , this being a increase on last month's 69 but remains ahead of our M9 forecast . Teams have refreshed their plans to April 2020, the current forecast for the end of March 2020 is 12 (with the goal of achieving zero still in place). There are a number of actions within the plans that are rag rated RED - use of Limited Liability Partnership, volume of outsourcing (CareUK) that can be utilised and availablity of theatre staff for weekend working. Capacity has already been lost in December and it is likely that January will also be lost - if plans are not delivered there is the potential to have circa 70-90 52wk breaches at 31 March 2020. With delivery of plans we forecast to still have 20 breaches through patient choice.
Increased levels of insourcing will continue for Gastro and Ophthalmology.

The Two Graphs below show how number on waiting lists have increased since September 2018.



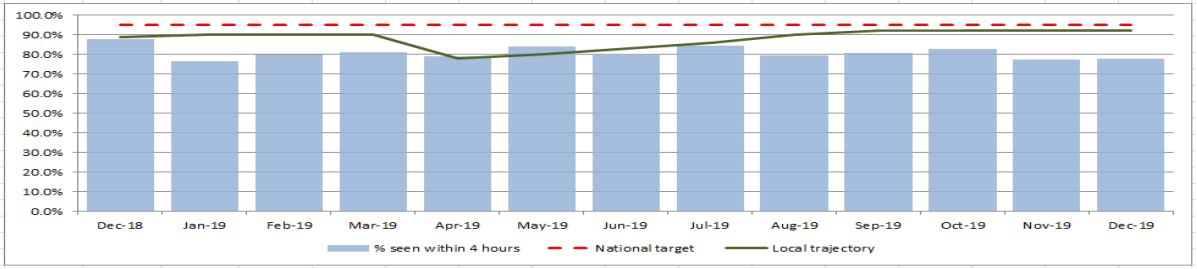


Management action: Led by the Chief Operating Officer plans are monitored through the Cancer / RTT Performance Risk and Assurance meeting with a ny outstanding risk escalated to the monthly Assurance and Transformation meeting.

NHSI indicator - 4 hours - time spent in Accident and Emergency Department

A&E and MIU patients seen within 4 hours

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Patients	8458	8708	8168	9458	9611	10015	9942	10909	10741	9690	9326	9093	9217
4 hour breaches	1046	2054	1646	1798	2013	1586	1960	1715	2217	1868	1618	2064	2038
% seen within 4 hours	87.6%	76.4%	79.8%	81.0%	79.1%	84.2%	80.3%	84.3%	79.4%	80.7%	82.7%	77.3%	77.9%
National target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Local trajectory	88.8%	90.0%	90.0%	90.0%	78.0%	80.0%	83.0%	86.0%	90.0%	92.0%	92.0%	92.0%	92.0%



Acute Care model - The acute care model is critical to delivery of improved ED performance by ensuring patients for medical review are fast tracked away from ED for medical assessment and initiation of treatment.
Corridor Care - The performance Dashboard recorded the number of patient who receive care in the ED corridor. This remains a priority to eliminate through our plane to change the model of front door care. In December we recorded 463 patient over 60 minutes in the ED corridor
Overall time in department - The number of patient who spend over 12 hours in the department is recorded in the performance dashboard. in December we recorded 158 patients.

Operational delivery: The Operational Plan trajectory for Accident and Emergency waiting times (less than 4 hours) is not met in December (92% trajectory) with 77.9**%** (77.3% last month.
Improvement work streams: The three' task and finish' groups are receiving additional improvement and project management support to ensure robustness of plans and to support system delivery over the coming months to achieve an improvement trajectory to 84% by March.
The 3 groups are :

- Emergency floor and front door assessment model
- Wards - To improve the quality, safety and minimise length of stay for urgent and emergency patients on inpatient wards;
- Home First - To enable safe and effective urgent and emergency care as close as possible to patients' home.

NHSI improvement team support in place:

- Improvement manager from ECIST : working with the urgent and emergency teams to continue to support the improvement strategy
- ED workforce planning : support the leadership team in their workforce capacity and demand modelling work.
- ECIST Medical Director will be visiting the Trust and working closely with our senior team to provide advice and guidance on our medical model.

12 hour Trolley wait : In December, three patients are reported as having a trolley wait from decision to admit to admission to an inpatient bed of over 12 hours.
Ambulance Handovers : In December we have seen a slight increase in the number of ambulance delays over 60 minutes with 14 reported.
Two additional measures have been included on the Dashboard this month:

1. Greater than 60 min corridor care;
2. Greater than 12 hour A&E visit time.

Escalation status

Opel status	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Opel 1	9	0	0	1	0	6	0	0	0	2	0	0	0
Opel 2	13	1	5	10	8	15	4	5	3	13	12	3	8
Opel 3	7	22	20	16	16	3	18	22	21	11	19	18	15
Opel 4	2	8	3	4	6	4	8	4	7	4	0	9	8
Performance	87.6%	76.4%	79.8%	81%	79.1%	84.2%	80.3%	84.3%	79.4%	80.7%	82.7%	77.3%	77.9%

Escalation: In December there were no days at Opel 1 and 8 days at Opel 4, the highest level of escalation. The current level of performance remains a significant risk; we continue to focus on the improvement programme.

Cancer treatment and cancer access standards

CWT Measure	Target	November 2019				December 2019			
		Within Target	Breached Target	Total	Performance	Within Target	Breached Target	Total	Performance
14 Day - 2ww referral	93%	1130	321	1451	77.9%	1031	175	1206	85.5%
14 Day - Breast Symptomatic referral	93%	90	0	90	100.0%	77	2	79	97.5%
31 Day 1st treatment	96%	202	4	206	98.1%	166	4	170	97.6%
31 Day Subsequent treatment - Drug	98%	91	0	91	100.0%	73	0	73	100.0%
31 Day Subsequent treatment - Radiotherapy	94%	70	3	73	95.9%	60	3	63	95.2%
31 Day Subsequent treatment - Surgical	94%	38	2	40	95.0%	37	1	38	97.4%
31 Day Subsequent treatment - Other		0	0	0	100.0%	21	0	21	100.0%
62 day 2ww / Breast	85%	93	25	118	78.8%	84	14.5	98.5	85.3%
62 day Screening	90%	12	2	14	85.7%	9	0	9	100.0%
62 day Consultant Upgrade		4.5	0.5	5	90.0%	4	0	4	100.0%

Cancer standards - The table above shows the position for December 2019 (as at 15 January 2020). *Final validation and data entry is completed for national submission, 25 working days following the month close and at the end of the quarter.*
One cancer standard is not met in December 2019.

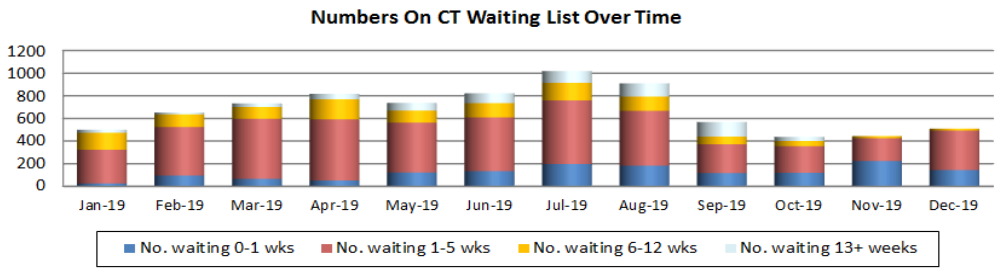
Urgent cancer referrals 14 day 2ww: At 85.5% in December this remains below the standard of 93%, however as a pilot site for developing the new standard for "28 days from referral to diagnosis" some variance in performance is expected as this new pathway is introduced. The improvement plans to increase capacity to see urgent outpatients in Urology and lower GI pathways however are on track.

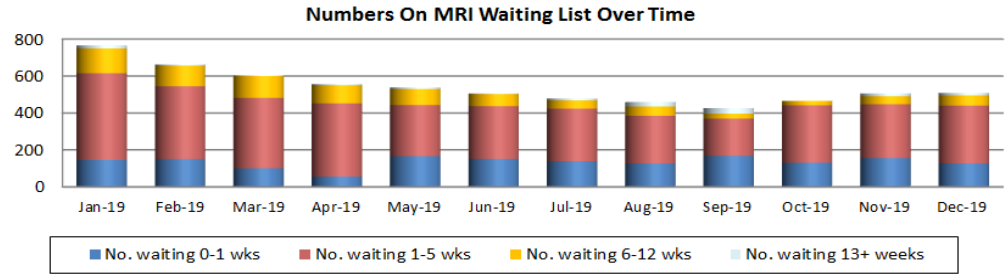
NHSI monitored Cancer 62 day standard: The 62 day referral to treatment standard has been met in December at 85.3%.
Significant risk remains in the pathways for Urology and Lower GI .

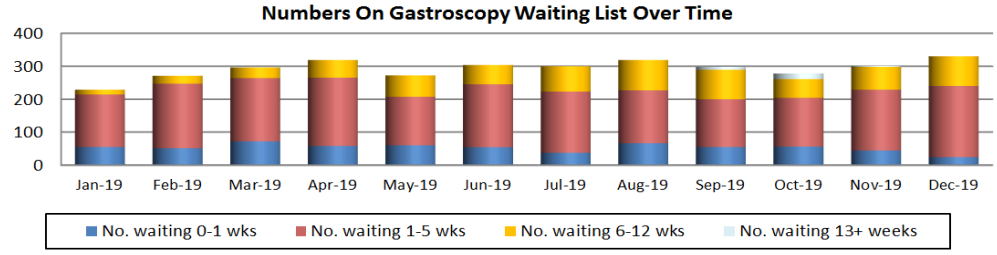
31 day subsequent treatment - surgical: The standard is met in December with 97.4 % against a standard of 94%.

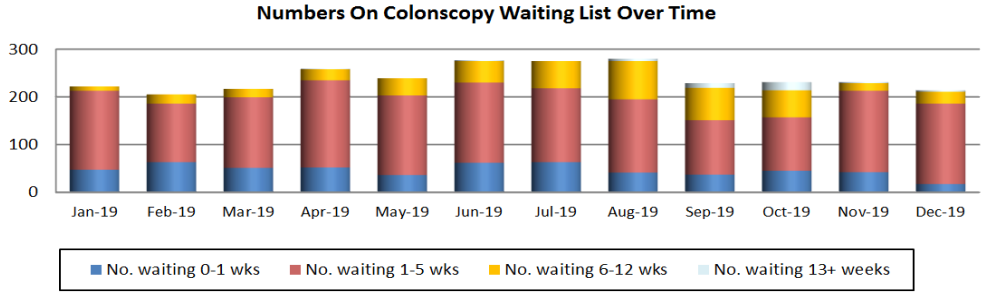
Longest waits greater than 104 days on the 62 day referral to treatment pathway:
In December , 3 patients with confirmed cancer were treated 104 days. The number of patients being tracked over 62 days is being maintained with no significant change to historical levels.
There are 24 patients on a 104 day open pathway , these patients are reviewed and managed through Cancer Services via the RTT Risk and Assurance Group.

NHSI indictor - patients waiting over 6 weeks for diagnostics



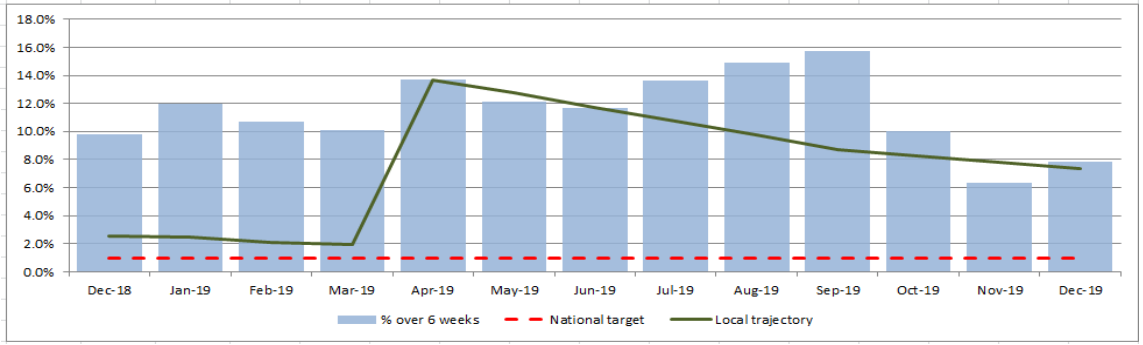






Diagnostic tests longer than the 6 week standard

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Patients	379	405	421	423	575	454	454	527	535	460	282	182	240
Waiting longer than 6 weeks	3863	3385	3934	4186	4201	3746	3893	3862	3586	2926	2823	2865	3051
% over 6 weeks	9.8%	12.0%	10.7%	10.1%	13.7%	12.1%	11.7%	13.6%	14.9%	15.7%	10.0%	6.4%	7.9%
National target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Local trajectory	2.6%	2.4%	2.1%	2.0%	13.7%	12.7%	11.8%	10.8%	9.7%	8.7%	8.3%	7.8%	7.3%



Good progress has been seen with the percentage of patients with a diagnostic wait over 6 weeks only slightly increasing in December to 7.9% (240 patients > 6 weeks) from 6.4% (182 patients > 6 weeks) in November; this remains above our trajectory of improvement. The greatest improvement being seen in CT as a result of the increased mobile van capacity.

Demand for CT MRI and gastro investigations exceed the maximum in house capacity (which includes extended days and weekend working). Utilisation of mobile van capacity remains in place to support this capacity shortfall in CT and MRI. In the longer term the plan is to commission a 3rd CT scanner in 20_21 and continue to commission additional insourcing as needed.

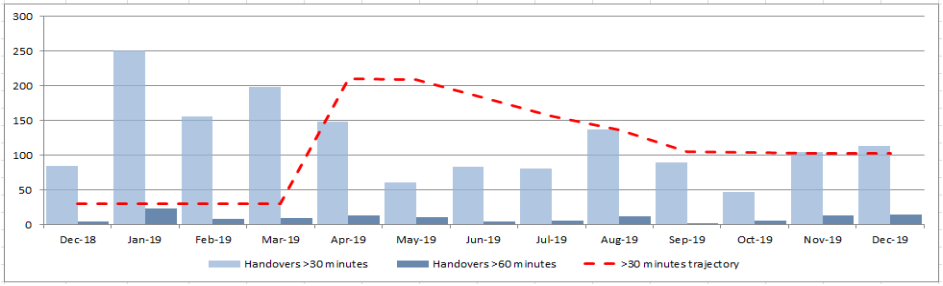
Insourcing at weekends to run additional colonoscopy lists is continuing with 1 in 3 weekends.

Access to diagnostics, and in particular radiology, is critical for maintaining timely cancer diagnosis and supporting treatment pathways. The radiology service continues to prioritise these urgent referrals along with maintaining service levels to inpatients, however ,it does mean that overall some patients will wait longer for routine diagnostic tests.

Other performance exceptions

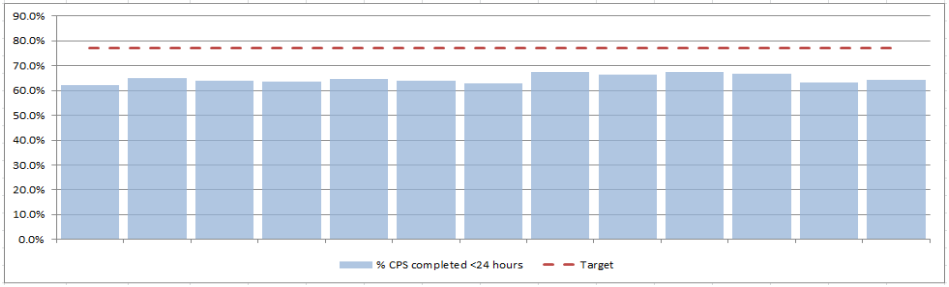
Ambulance handovers

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Handovers >30 minutes	84	251	156	198	148	61	83	81	137	90	47	104	113
Handovers >60 minutes	4	23	8	9	13	11	4	5	12	2	5	13	14
>30 minutes trajectory	30	30	30	30	210	209	183	157	136	105	104	103	103



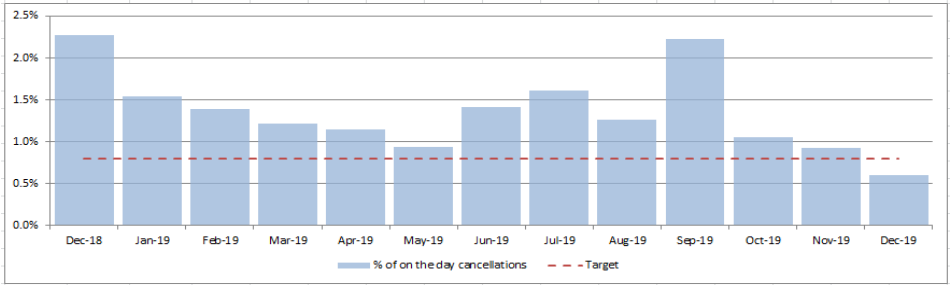
Care Plan Summaries completed within 24 hours of discharge - Weekday

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Discharges	1621	1750	1525	1639	1690	1818	1526	1804	1593	1566	1814	1627	1668
CPS completed within 24 hours	1006	1135	976	1043	1094	1161	959	1214	1059	1056	1209	1027	1072
% CPS completed <24 hours	62.1%	64.9%	64.0%	63.6%	64.7%	63.9%	62.8%	67.3%	66.5%	67.4%	66.6%	63.1%	64.3%
Target	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%



On the day cancellations for elective operations

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Cancellations	63	53	42	39	37	33	45	56	41	72	38	33	19
Elective spells	2782	3432	3016	3196	3218	3502	3198	3481	3248	3237	3616	3567	3133
% of on the day cancellations	2.3%	1.5%	1.4%	1.2%	1.1%	0.9%	1.4%	1.6%	1.3%	2.2%	1.1%	0.9%	0.6%
Target	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%



Ambulance Handover

The number of ambulance handovers delayed increased In December.

We routinely validate delays and these are now being reflected in the published data received from SWAST.

The longest delays being those over 60 minutes are being managed with clinical prioritisation and escalation processes in place.

Care Planning Summaries (CPS)

Improvement remains a challenge to complete CPSs within 24 hours of discharge.
The challenges remain with the manual processes and duplication of information already recorded. The strategy is to reduce the manual entry requirements and demands on junior doctor time by increasing the automatic transfer of data from existing electronic records.

Cancelled operations

In December the number of operations cancelled on the day of surgery for hospital reasons decreased to 19. This represents 0.6% of all elective procedures undertaken.
There has been a focus on prioritising patients who have waited a long time for their surgery.

Finance Focus

Page 2	Summary Of Financial Forecast
Page 3	Summary Of Financial Performance
Page 4	Summary Of Financial Performance (2)
Page 5	Income
Page 6	Income (2)
Page 7	Pay Expenditure
Page 8	Pay Expenditure (2)
Page 9	Non Pay Expenditure
Page 10	Financial Position by System
Page 11	Cash
Page 12	Capital
Page 13	Activity
Page 14	Continuous Improvements Program (CIP) 1

Summary of Financial Forecast

The Regulator Protocol for Change to Forecast Outturn has been followed which required governance within the Trust and STP before review at the regional office of the regulator. The Trust is now monitoring against this forecast change which show a deficit position of £18.8m against a £3.8m control total, a variance to plan of £15.0m at year end after mitigating actions.

There has been an improvement in the baseline position from the M6 Forecast due to additional income received and lower pay offset by increase in operating cost.
At month 9 the I&E showed a small positive variance (£352k) to forecast, however it is expected that the year end variance to control total will remain £15.0m.

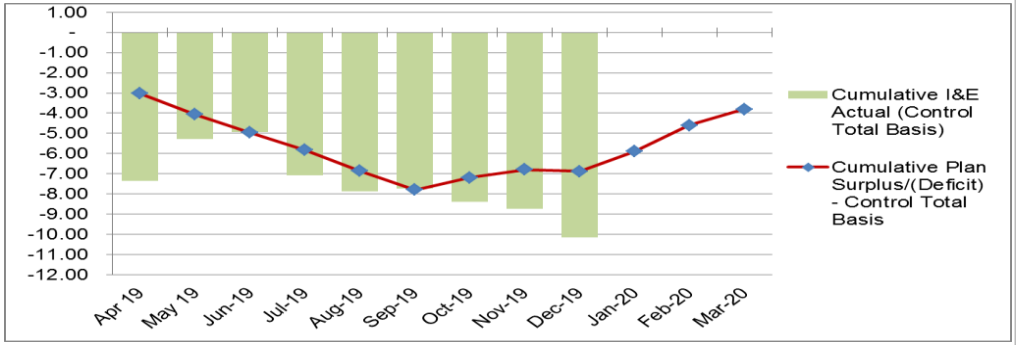
There remain some risks to the delivery of the £15.0m adverse variance to control total such as achievement of remaining CIP target (£2.2m) recovery items (£0.6m), an adjustment to depreciation charges owing to a change in RICS guidance (£1.8m) and unforeseen costs due to operational pressures. Steps are being taken to mitigate these risks.

The latest position is shown below:

	M9	
	(Adverse) Favourable £000	(Adverse) Favourable £000
Forecast Outturn Variance against Plan (based on month 9)		(£18,804)
Recovery Actions		
Integrated Service Units	£1,731	
RICS (subject to further review and external audit process)	£1,800	
Technical / further Recovery Actions	£273	
		£3,804
Revised Forecast Outturn Variance against Plan		**(£15,000)**

Summary of Financial Performance

Current Performance



	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Annual Plan	Annual Budget
	£M	£M	£M	£M	£M	£M	£M
Income	370.57	(1.49)	369.08	367.44	(1.64)	496.18	493.67
Pay	(186.21)	(2.09)	(188.30)	(191.88)	(3.58)	(246.38)	(249.27)
Non Pay	(170.36)	2.70	(167.66)	(168.11)	(0.45)	(225.02)	(222.11)
EBITDA	**14.01**	**(0.88)**	**13.13**	**7.45**	**(5.68)**	**24.78**	**22.30**
Financing Costs	(14.95)	1.86	(13.09)	(12.83)	0.26	(20.08)	(17.60)
SURPLUS / (DEFICIT)	**(0.94)**	**0.98**	**0.04**	**(5.38)**	**(5.42)**	**4.70**	**4.70**
NHSI Exclusions	(0.10)	0.00	(0.10)	(0.01)	0.09	(0.14)	(0.14)
Plan Adjusted Surplus / (Deficit)	**(1.05)**	**0.98**	**(0.07)**	**(5.39)**	**(5.32)**	**4.56**	**4.56**
Remove PSF/MRET Income	(5.82)	0.00	(5.82)	(4.75)	1.07	(8.36)	(8.36)
Variance to Control Total (Excl PSF/MRET	**(6.87)**	**0.98**	**(5.89)**	**(10.14)**	**(4.25)**	**(3.80)**	**(3.80)**
Cash Balance	1.15			6.00	**4.85**	**3.83**	**3.83**
Capital Expenditure	14.77	(1.96)	12.81	7.14	**(5.67)**	**21.56**	**19.57**
CIP Delivery	11.07	0.00	11.07	8.20	**(2.87)**	**20.03**	**20.03**

KPIs (Risk Rating)	YTD Plan	YTD Actual
Indicator	**Rating**	**Rating**
Capital Service cover rating	4	4
Liquidity rating	4	4
I&E Margin rating	3	4
I&E Margin variance rating	n/a	3
Agency rating	2	4
Finance Risk Rating	**n/a**	**4**

Key Points

- The Trust has a Control Total for the year of a deficit of £3.80m, which excludes income relating to Provider Sustainability Fund (PSF) and Marginal Rate Emergency Tariff (MRET) totalling £8.36m.
- The financial position at 31st of December 2019 is a £10.14m deficit prior to sustainabilty funding. This is £3.27m adverse against the phased YTD plan of £6.87m deficit. The Trust implemented the protocol for changing its forecast outturn in month 6, which means that the control total for the year will not be achieved. The Trust has assumed that it will not implement the revised RICS guidance for MEA on the grounds of materiality which has meant there is an additional benefit since month 7. This has yet to be scrutinised by the external auditors.
- In months 1 to 6 the Trust earned the PSF and MRET funding of £3.51m (as the Trust delivered the control total in that period). From M7 onwards, only MRET income is expected due to projected non delivery of control total.
- There is a net movement in re-categorisation of plan to budget of £0.20m in month relating mainly to income, non pay and asset life changes due to RICS valuation.
- Total pay run rate in M9 (£21.3m) is higher in comparison to previous month (M8 £20.9m); due to higher substantive and Bank spend.
- Non pay expenditure run rate of £19.25m is higher by £0.87m compared to M8 (£18.37m). Higher spend is due to: purchase of healthcare £0.41m, social care cost £0.16m, premises £0.16m, change in discount rate of provision £0.34m, various operating cost £0.34m offset by lower spend in clinical supplies and services £0.18m, general supplies £0.07m, Drugs £0.13m and impairment of receivable £0.16m.
- In the year to date, the Trust has delivered £8.2m of savings, which is £2.9m adverse to the original plan; of this £2.6m has been delivered recurrently.
- The Trust identified an annual savings requirement of £20.0m. Of this £10.3m savings have been identified, resulting in a £9.7m gap and representing a significant risk to the underlying financial performance and the opening position for next financial year.
- Capital expenditure as at M9 is £7.1m. The full year forecast is £18.7m. Between now and the end of the year, it is expected that we will spend £11.6m for the following schemes: purchase of high value medical equipment £4.1m, continuation of Theatres upgrade and refurbishment of £3.3m, material investment in IT of £3.6m namely purchase of PC's and upgrade of Microsoft licenses and Torbay Pharmaceutical (TP) equipment lease of £0.6m.
- The Finance Risk Rating is a 4.
- Trust continues to forecast an adverse variance to plan of £15.0m in line with the month 6 position reported to the regulator despite a small positive variance (£352k) in M9. There remain some risks to the delivery of the £15.0m adverse variance to control total such as achievement of remaining CIP target (£2.2m), recovery items (£0.6m), an adjustment to depreciation charges owing to a change in RICS guidance (£1.8m) and unforeseen costs due to operational pressures. Steps are being taken to mitigate these risks.

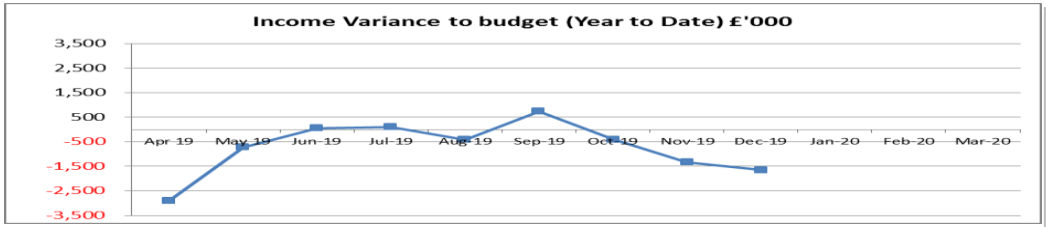
Summary of Financial Performance

	Month 9					Year to date								
	Current Month Plan	Re-Categorisation of Plan	Current Month Budget	Current Month Actual	Current Month Variance to Budget	Plan for Period YTD	Re-Categorisation of Plan	Budget for Period YTD	Actual for Period YTD	Variance to Budget YTD	Prior Month Variance YTD	Change	Annual Plan	Annual Budget
	£M	£M	£M	£M	£M	£M	£M	£M	£M	£M	£M	£M	£M	£M
Operating income from patient care activities	36.98	(0.38)	36.60	36.33	(0.27)	333.22	(1.99)	331.23	329.07	(2.16)	(1.89)	(0.27)	444.27	441.13
Other Operating income	4.53	0.03	4.56	4.52	(0.04)	37.35	0.50	37.85	38.36	0.51	0.55	(0.04)	51.91	52.54
Total Income	**41.50**	**(0.35)**	**41.16**	**40.85**	**(0.31)**	**370.57**	**(1.49)**	**369.08**	**367.44**	**(1.64)**	**(1.34)**	**(0.31)**	**496.18**	**493.67**
Employee Benefits - Substantive	(19.91)	(0.01)	(19.92)	(20.62)	(0.69)	(181.22)	(1.69)	(182.91)	(184.69)	(1.78)	(1.09)	(0.69)	(240.20)	(242.28)
Employee Benefits - Agency	(0.40)	0.00	(0.40)	(0.67)	(0.27)	(4.99)	(0.40)	(5.39)	(7.19)	(1.80)	(1.53)	(0.27)	(6.18)	(6.99)
Drugs (including Pass Through)	(2.94)	0.10	(2.83)	(2.73)	0.10	(26.44)	0.92	(25.52)	(25.00)	0.52	0.42	0.10	(35.26)	(34.02)
Clinical Supplies	(2.24)	(0.02)	(2.25)	(2.21)	0.05	(19.67)	(0.17)	(19.85)	(20.32)	(0.48)	(0.52)	0.05	(26.47)	(26.68)
Non Clinical Supplies	(0.41)	(0.10)	(0.51)	(0.32)	0.18	(3.78)	(0.19)	(3.97)	(3.51)	0.46	0.27	0.18	(4.94)	(5.10)
Other Operating Expenditure	(13.20)	(0.03)	(13.23)	(13.99)	(0.76)	(120.46)	2.14	(118.32)	(119.28)	(0.95)	(0.19)	(0.76)	(158.35)	(156.30)
Total Expense	**(39.10)**	**(0.05)**	**(39.15)**	**(40.53)**	**(1.39)**	**(356.57)**	**0.61**	**(355.96)**	**(359.99)**	**(4.03)**	**(2.65)**	**(1.39)**	**(471.40)**	**(471.38)**
EBITDA	**2.40**	**(0.40)**	**2.01**	**0.31**	**(1.69)**	**14.01**	**(0.88)**	**13.13**	**7.45**	**(5.68)**	**(3.98)**	**(1.69)**	**24.78**	**22.30**
Depreciation - Owned	(1.09)	0.21	(0.89)	(0.81)	0.08	(9.53)	1.86	(7.67)	(7.50)	0.17	0.09	0.08	(12.86)	(10.38)
Depreciation - donated/granted	(0.07)	0.00	(0.07)	(0.09)	(0.01)	(0.65)	0.00	(0.65)	(0.67)	(0.02)	(0.01)	(0.01)	(0.86)	(0.86)
Interest Expense, PDC Dividend	(0.61)	0.00	(0.61)	(0.59)	0.03	(5.52)	0.00	(5.52)	(5.29)	0.23	0.21	0.03	(7.36)	(7.36)
Donated Asset Income	0.08	0.00	0.08	0.70	0.62	0.75	0.00	0.75	0.77	0.02	(0.59)	0.62	1.00	1.00
Gain / Loss on Asset Disposal	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.05)	(0.05)	(0.05)	0.00	0.00	0.00
Impairment	0.00	0.00	0.00	(0.02)	(0.02)	0.00	0.00	0.00	(0.10)	(0.10)	(0.07)	(0.02)	0.00	0.00
SURPLUS / (DEFICIT)	**0.71**	**(0.19)**	**0.52**	**(0.49)**	**(1.01)**	**(0.94)**	**0.98**	**0.04**	**(5.38)**	**(5.42)**	**(4.41)**	**(1.01)**	**4.70**	**4.70**
Adjusted Plan Position														
Donated Asset Income	(0.08)	0.00	(0.08)	(0.70)	(0.62)	(0.75)	0.00	(0.75)	(0.77)	(0.02)	0.59	(0.62)	(1.00)	(1.00)
Depreciation - Donated / Granted	0.07	0.00	0.07	0.09	0.01	0.65	0.00	0.65	0.67	0.02	0.01	0.01	0.86	0.86
Impairment	0.00	0.00	0.00	0.02	0.02	0.00	0.00	0.00	0.10	0.10	0.07	0.02	0.00	0.00
Adjusted Plan Surplus / (Deficit)	**0.70**	**(0.19)**	**0.51**	**(1.08)**	**(1.59)**	**(1.05)**	**0.98**	**(0.07)**	**(5.39)**	**(5.32)**	**(3.73)**	**(1.59)**	**4.56**	**4.56**
NHSI Adjustment to Control Total														
Remove PSF/MRET Income	(0.77)	0.00	(0.77)	(0.32)	0.45	(5.82)	0.00	(5.82)	(4.75)	1.07	0.62	0.45	(8.36)	(8.36)
Variance to Control Total Excluding PSF/MRET	**(0.07)**	**(0.19)**	**(0.26)**	**(1.41)**	**(1.14)**	**(6.87)**	**0.98**	**(5.89)**	**(10.14)**	**(4.25)**	**(3.11)**	**(1.14)**	**(3.80)**	**(3.80)**

- The in-month deficit for month 9 is £1.41m, which is adverse to the £0.07m budgeted position after NHSI exclusions. There is a net movement in re-categorisation of plan to budget of £0.20m in month relating mainly to income, non pay and asset life changes due to RICS valuation. The year to date position is a cumulative deficit of £10.14m.
- Patient care income is £0.27m lower than budget in month 9 mainly due to Torbay council income; cumulatively income is £2.16m lower than budget due to: lower contract healthcare activity £0.79m, council income £1.70m, private patient income £0.42m offset by client income £0.65m and other £0.11m. Other income is slightly lower in M9. Cumulatively other income is £0.51m higher than budget due to: Education, Grant and Training income of £0.81m, income CIP £0.27m, site services £0.10m, non patient services £0.23m and various other income £0.38m offset by lower PSF of £1.07m and TP sales £0.20m.
- Pay expenditure of £21.29m is £0.96m higher than budget in Month 9 due to: use of Bank £0.37m, Agency £0.27m and Substantive staff £0.32m due to undelivered CIP. For the year to date, the pay position is £3.58m higher than budget due to undelivered CIP £2.90m, Bank and Agency spend £4.76m offset by Substantive vacancies and underspends £4.08m. The higher than budgeted use of Bank and Agency is due to challenges in recruiting for Medical and Nursing staff, sickness cover and operational pressures. In addition the Trust is not meeting the CIP target as originally planned.
- Non-pay expenditure is £0.43m higher than budget in Month 9 due to higher spend in operating cost £0.76m (mainly due to change in discount rate in provision £0.34m and purchase of healthcare services £0.30m) offset by lower Drugs £0.10m, Clinical suplies £0.05m and non clinical supplies £0.18m. The year to date position is £0.45m higher than budget due to overspend of £0.95m in operating cost (Adult social care packages of care and CIP £0.82, Placed people £0.46m offset by net lower operating cost £0.33m) and clinical supplies of £0.48m offset by Drugs £0.52m and non clinical supplies £0.46m.
- Depreciation/amortisation costs is £0.15m lower than budget year to date.

Income

Current Performance



Operating Income	Year to Date - Month 9					Previous Month	
	Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Variance to Budget - (adv)/+fav	Change
	£m	£m	£m	£m	£m	£m	£m
Contract Healthcare	284.59	(1.48)	283.11	282.32	(0.79)	(0.69)	(0.10)
Council Social Care (inc Public Health)	38.88	(0.30)	38.58	36.88	(1.70)	(1.45)	(0.25)
Client Income	8.09	(0.46)	7.63	8.28	0.65	0.54	0.11
Private Patients	1.67	0.06	1.73	1.31	(0.42)	(0.34)	(0.08)
Other Income	0.00	0.20	0.20	0.30	0.11	0.04	0.07
Operating Income from patient care activities	**333.22**	**(1.98)**	**331.23**	**329.08**	**(2.16)**	**(1.89)**	**(0.26)**
Other Income	23.98	0.68	24.66	25.44	0.78	0.53	0.25
R&D / Education & training revenue	7.55	(0.18)	7.37	8.18	0.81	0.65	0.16
Provider Sustainability Fund (PSF) & MRET Income	5.82	0.00	5.82	4.75	(1.07)	(0.62)	(0.45)
Other operating income	**37.35**	**0.50**	**37.85**	**38.37**	**0.51**	**0.55**	**(0.04)**
Total	**370.57**	**(1.49)**	**369.09**	**367.44**	**(1.65)**	**(1.34)**	**(0.31)**

Contract income by Commissioner	Year to Date - Month 9					Previous Month	
	Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Variance to Budget - (adv)/+fav	Change
	£m	£m	£m	£m	£m	£m	£m
Devon Clinical Commissioning Group (CCG)	174.93	(1.00)	173.93	174.17	0.24	0.29	(0.05)
NHS England - Area Team	5.40	0.00	5.40	5.34	(0.06)	(0.05)	(0.01)
NHS England - Specialist Commissioning	23.66	(0.23)	23.43	23.37	(0.06)	0.05	(0.11)
Acute Income - Other Commissioners	7.87	(1.18)	6.69	5.64	(1.05)	(1.10)	0.05
Sub-Total Acute Income	211.85	(2.41)	209.45	208.52	(0.93)	(0.81)	(0.12)
Devon CCG (Placed People and Community Health)	71.67	0.00	71.67	71.67	0.00	0.00	0.00
Community Income - Other Commissioners	1.07	0.92	1.99	2.12	0.14	0.12	0.02
Sub Total Community Income	72.74	0.92	73.66	73.79	0.14	0.12	0.02
Operating Income from patient care activities	**284.59**	**(1.48)**	**283.11**	**282.32**	**(0.79)**	**(0.69)**	**(0.10)**

Key points

- The agreement of the Devon CCG income plan has been reflected in the position from month 2. No penalties have been assumed for 52 week waits and no STP/ CCG risk share has been applied in months 1 to 9.
- Overall operating income is £1.65m behind budget for the year to date. The majority of this variance is accounted for by the £2.16m adverse variance on operating income described below plus £1.07m of foregone sustainability funding, offset by overperformance in other income streams.
- Operating Income from Patient Care Activities in M9 is lower than budget by £2.16m.
- Within this, income from contract healthcare is £0.79m behind budget due to lower activity with: NHS England re: dental services and also other commissioners linked to 'out of area' patients.
- Council social care income is behind by £1.70m mainly due to not receiving IBCF income from Torbay Council (*contract discussions are ongoing*).
- Client income is ahead by £0.65m as at M9.
- Private patient income is behind budget by £0.42m due to lower Outpatient activity.
- Other income is £0.11m ahead of budget at M9.

Income

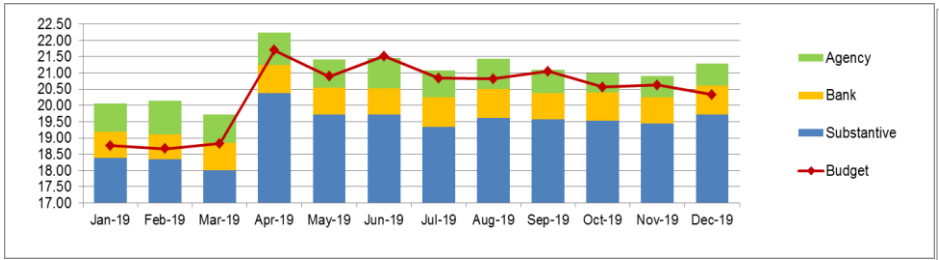
Other Operating Income	Year to Date - Month 9					Previous Month	
	Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Variance to Plan - (adv)/+fav	Change
	£m	£m	£m	£m	£m	£m	£m
R&D / Education & training revenue	7.55	(0.18)	7.37	8.18	0.81	0.65	0.16
Site Services	1.75	0.10	1.84	1.94	0.10	0.10	(0.00)
Revenue from non-patient services to other bodies	3.59	0.83	4.42	4.66	0.23	(0.02)	0.26
Provider Sustainability Fund (PSF) & MRET Income	5.82	0.00	5.82	4.75	(1.07)	(0.62)	(0.45)
Misc. other operating revenue	18.64	(0.24)	18.40	18.85	0.45	0.46	(0.01)
Total	**37.35**	**0.50**	**37.85**	**38.37**	**0.51**	**0.55**	**(0.04)**

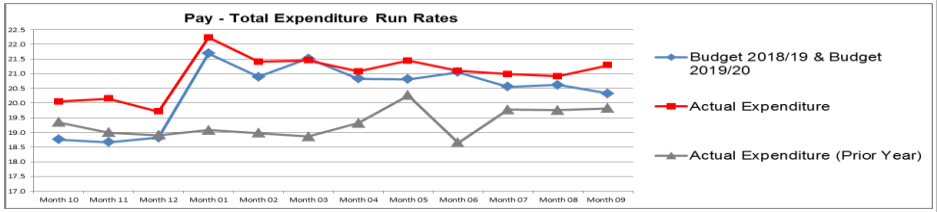
At Month 9, Other Operating income is £0.51m ahead of budget.
Key headlines / variances are:

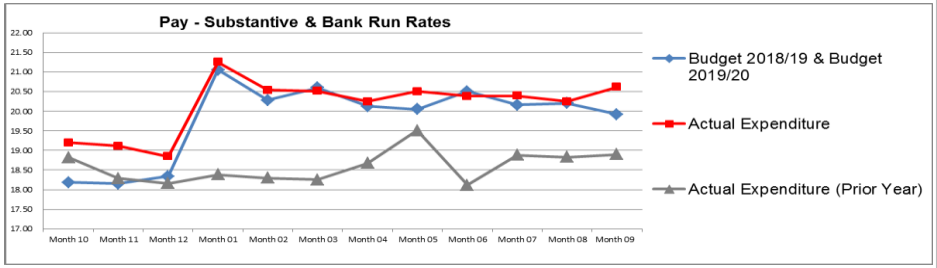
- R&D, Education and Grant income ahead of budget by £0.81m due to: higher SIFT/NMET/MADEL income of £0.24m and grant income of £0.57m for CFHD training (matched by Cost) .
- Site Services (Car Parking, Catering and Accommodation) income is slightly higher than budget by £0.10m.
- Non patient services to other bodies £0.23m higher than budget.
- Provider Sustainability Fund (PSF) is lower than plan by £1.07m year to date due to not earning the PSF income of £1.35m since M7 offset by additional income received re: FY 2018/19 of £0.27m. Marginal Rate Emergency Tariff (MRET) income is in line with plan.
- Other Income is higher than budget by £0.45m due to income CIP £0.27m and various income received £0.38m offset by lower TP sales of £0.20m.

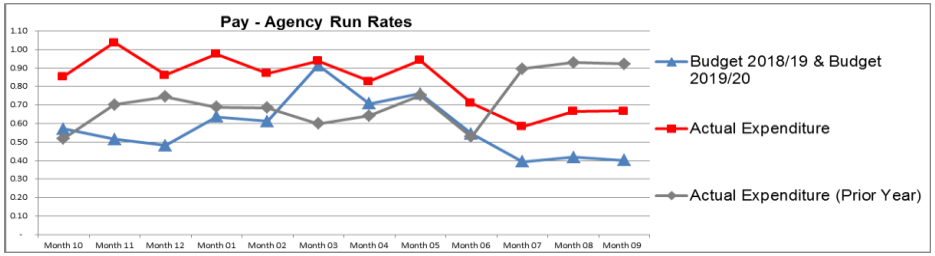
Pay Expenditure

Current Performance









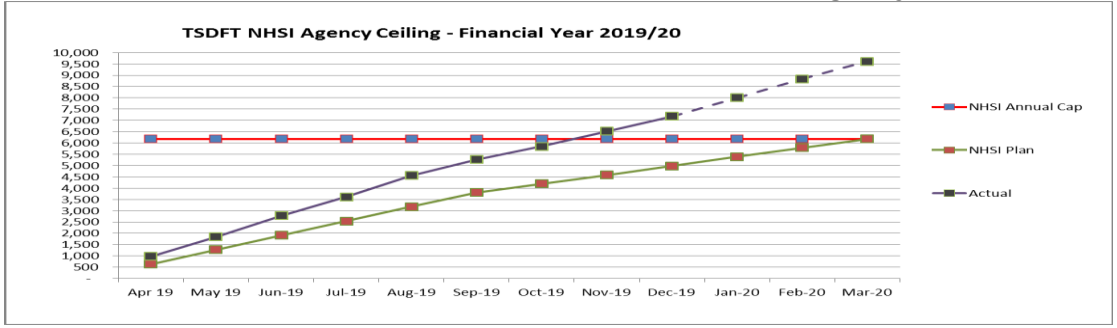
	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Annual Plan	Annual Budget
	£M	£M	£M	£M	£M	£M	£M
Medical and Dental	(39.65)	(0.71)	(40.35)	(42.26)	(1.91)	(52.78)	(53.71)
Nursing and Midwifery	(43.55)	0.02	(43.53)	(44.97)	(1.44)	(57.87)	(57.83)
Other Clinical	(71.77)	(0.97)	(72.74)	(71.16)	1.57	(94.71)	(96.19)
Non Clinical	(31.24)	(0.43)	(31.67)	(33.47)	(1.80)	(41.02)	(41.54)
Total Pay Expenditure	**(186.21)**	**(2.09)**	**(188.29)**	**(191.87)**	**(3.58)**	**(246.38)**	**(249.26)**

Key points

- Total pay costs are showing an overspend against year to date budget at Month 9 of £3.58m. This is due to undelivered CIP £2.90m, Bank and Agency spend £4.76m offset by Substantive vacancies and underspends £4.08m.
- In setting the annual plan, agency budgets were set in line with the Agency Cap. At Integrated Service Unit (ISU) level, there are overspends within most ISUs due to continued reliance on agency staff.
- Agency overspend of £1.80m is mainly due to increased use of Medical Staff £1.08m, Nursing staff £0.49m and non clinical/other staff £0.23m. This is due to challenges in recruiting for Medical and Nursing staff, sickness cover and operational pressures.
- Total pay run rate in M9 (£21.3m) is £0.4m higher in comparison to previous month (M8 £20.9m) due to higher substantive cost of £0.3m (Consultant £0.1m and A&C £0.2m (£0.1m is linked to IBCF scheme)) and Bank £0.1m spend.
- Agency run rate is similar to M8 value of £0.67m, mainly in Medical £0.29m and Nursing £0.30m (50% in Emergency) staff group.
- The other clinical staff group variance of £1.57 to budget reflects challenges in recruitment in AHP and other scientific staff in the first 9 months.
- The variance on Non clinical staff of £1.80m reflects the Transformational CIP schemes being held in cental reserves at plan stage.
- The Apprentice levy balance at Month 9 is £1,500,455 (£1,512,101 at month 8). The Trust's apprenticeship strategy is reviewed regularly and actions being taken are as follows: schemes are constantly developed, Trust colleagues are liaising with providers to offer a wide range of training/courses and the Trust is also looking to share the funding to partner organisations (per the Apprentice levy guideline). The balance is lower this month however the risk of loss of unspent monies continues.

Pay Expenditure

Agency Spend Cap



Agency - All Staff Groups	Q1	Q2	M7	M8	M9	YTD 2019-20
	£m	£m	£m	£m	£m	£m
Agency Plan 2019/20 (NHSI Ceiling)						
Planned Agency Cost	(1.91)	(1.90)	(0.39)	(0.39)	(0.40)	(4.98)
Total Planned Staff Costs	(63.00)	(60.32)	(22.27)	(20.29)	(20.32)	(186.19)
% of Agency Costs against Total Staff Cost	***3%***	***3%***	***2%***	***2%***	***2%***	***2.7%***
Agency Actual Costs 2019/20						
Agency Cost	(2.78)	(2.48)	(0.58)	(0.67)	(0.67)	(7.19)
Actual Staff Cost	(65.39)	(64.00)	(21.08)	(20.13)	(22.30)	(192.90)
% of Agency Costs against Total Staff Cost	***4%***	***4%***	***3%***	***3%***	***3%***	***3.7%***
Agency Cost vs Plan	(0.88)	(0.58)	(0.20)	(0.28)	(0.26)	(2.21)
% of Agency Costs against Total Staff Cost	***1%***	***1%***	***1%***	***1%***	***1%***	***1.1%***

Agency - Nursing	Q1	Q2	M7	M8	M9	YTD 2019-20
	£m	**£m**	**£m**	**£m**	**£m**	**£m**
Agency Nurse Staff Cost	(0.96)	(0.87)	(0.27)	(0.27)	(0.30)	(2.66)
Actual Registered Nurse Staff Cost	(15.38)	(14.81)	(4.93)	(4.92)	(4.94)	(44.97)
% of Agency Costs against Nursing Staff Cost	***6%***	***6%***	***5%***	***6%***	***6%***	***6%***

Agency - Medical Staff	Q1	Q2	M7	M8	M9	YTD 2019-20
	£m	**£m**	**£m**	**£m**	**£m**	**£m**
Agency Medical Staff Cost	(1.59)	(1.36)	(0.28)	(0.31)	(0.29)	(3.83)
Actual Medical Staff Cost	(14.27)	(14.01)	(4.68)	(4.81)	(4.49)	(42.26)
% of Agency Costs against Medical Staff Cost	***11%***	***10%***	***6%***	***6%***	***7%***	***9%***

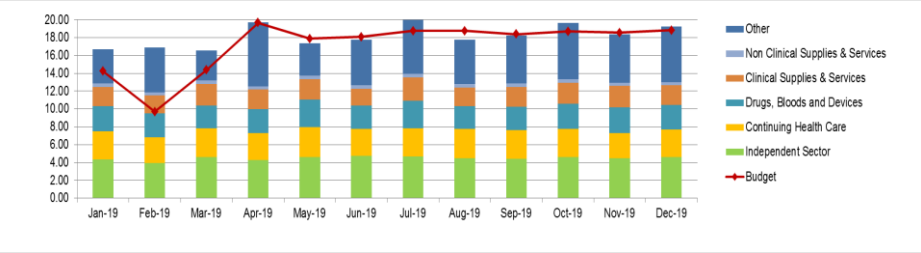
Agency staff cost in Month 9 across all staff groups is £0.67m. This is £0.26m higher than the NHSI cap of £0.40m.

The overall Agency Cap for the Trust is £6.18m in FY 2019/20, since M8 the Trust already breached this cap.

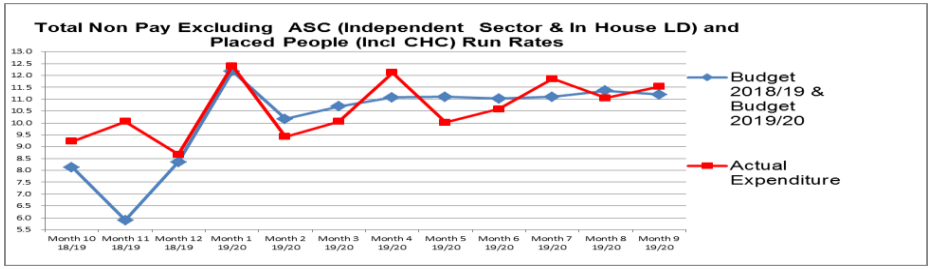
- The agency usage to date is £7.19m against a year to date cap of £4.98m which is £2.21m higher.
- Majority of the adverse agency cost variance of £2.21m is within Medical staff £1.65m and Nursing £0.39m due to challenges in recruiting for these staff group and operational pressures.
- Nursing agency spend in Month 9 is £0.30m which is higher than plan. Spend in month is slightly higher than the spend in M8.
- Medical agency spend is £0.29m in Month 9; year to date spend is £3.83m against a cap of £2.17m.
- The individual price rates for nursing and medical staff are all above NHSI individual shift rates.
- The forecast as at M9 is £9.61m before any mitigations, this is due to operational pressures, vacancy levels and difficulty in recruiting. This forecast will result in adverse variance of £3.43m.
- The Trust recruitment initiatives are constantly reviewed and actions are being taken e.g. overseas nursing recruitment, open recruitment days, medical staff recruitment and in house schemes like enhanced rate for HCA and Nursing bank pool and winter incentive payments.

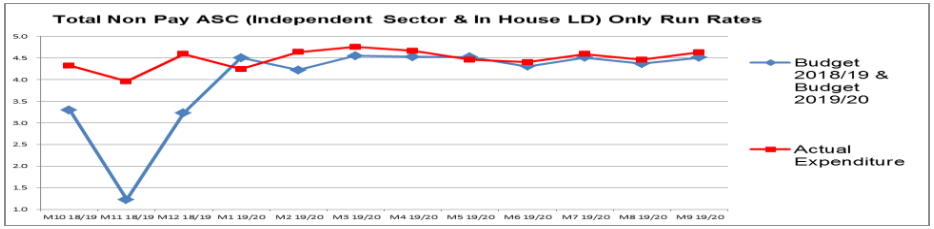
Non Pay Expenditure

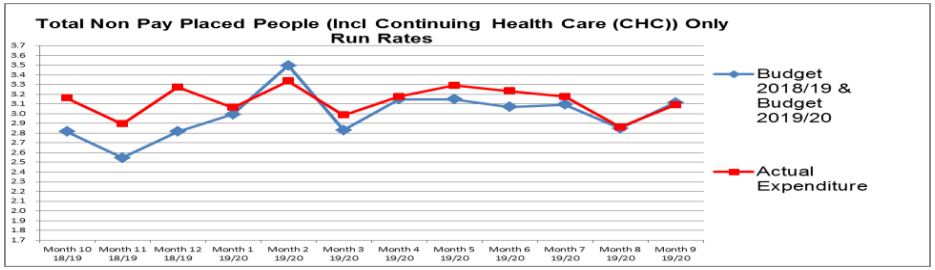
Current performance



Non Pay Expenditure	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Drugs, Bloods and Devices	(26.44)	0.92	(25.52)	(25.00)	0.52	(35.26)	(34.02)
Clinical Supplies & Services	(19.67)	(0.17)	(19.85)	(20.32)	(0.48)	(26.47)	(26.68)
Non Clinical Supplies & Services	(3.78)	(0.19)	(3.97)	(3.51)	0.46	(4.94)	(5.10)
Other Operating Expenditure	(58.37)	7.81	(50.55)	(50.22)	0.33	(75.70)	(66.09)
ASC (Independent Sector & In House LD)	(36.80)	(3.22)	(40.02)	(40.84)	(0.82)	(48.98)	(53.26)
Placed People (Incl Continuing Healthcare)	(25.30)	(2.46)	(27.76)	(28.21)	(0.46)	(33.67)	(36.95)
Total Non Pay Expenditure	**(170.36)**	**2.70**	**(167.66)**	**(168.11)**	**(0.45)**	**(225.02)**	**(222.11)**







Key Points

- Drugs, Bloods and Devices - Underspent by £0.52m mainly due to pass through for which income is similarly reduced for NHS England.
- Clinical Supplies – Spend is £0.48m higher than budget due to medical and surgical equipment £0.40m (increased Theatre activity), appliances and furniture £0.24m, lab medicine £0.16m, contract maintenance and service agreement £0.21m and TP finished goods £0.20m offset by Dressings £0.16m, chemical consumables £0.37m and hearing aids, dental, optical equipment and various supplies £0.20m underspends.
- Non Clinical Supplies – underspend of £0.46m due to external service agreements (records management, storage and other non healthcare) £0.18m, CIP £0.28m, domestic supplies £0.09m offset by hospitality provisions £0.07m and kitchen equipment £0.02m.
- Other Operating Expenditure - underspent by £0.33m reflecting lower provision for Bad debt £1.28m, net IT license cost deferral to next year of £0.68m, courses £0.10m, insurance rebate £0.10m offset by higher domiciliary care £0.18m, direct payments £0.33m, purchase of healthcare £0.36m, outsourcing £0.20m, provisions mainly due to change in discount rate £0.39m, consultancy £0.14m and various operating cost £0.24m.
- Adult Social Care (Independent sector) - Overspend by £0.82m mainly due to unachieved CIP and increased cost in packages of care.
- Placed People (including Continuing Healthcare) - overspend of £0.46m to date.

Financial Position by System

Key Drivers

The financial position at control total level as at 31st of December 2019 is a £10.14m deficit, which is £3.27m adverse against the plan of £6.87m. Further analysis by Income and Expenditure categories at System level can be seen in the following tables which includes Forecast and variance against budget:-

System	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget	Variance between Forecast and Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
South Devon									
Income	124.49	(0.03)	124.46	124.25	(0.21)	165.60	165.50	165.49	0.11
Pay	(72.85)	(2.98)	(75.83)	(78.77)	(2.94)	(105.31)	(97.13)	(101.29)	(4.03)
Non Pay	(22.02)	(1.01)	(23.02)	(23.18)	(0.15)	(31.19)	(29.35)	(29.99)	(1.20)
Financing Costs	(1.35)	0.00	(1.35)	(1.34)	0.00	(1.79)	(1.79)	(1.79)	0.01
Surplus / (Deficit)	**28.28**	**(4.01)**	**24.27**	**20.96**	**(3.30)**	**27.31**	**37.22**	**32.42**	**(5.11)**

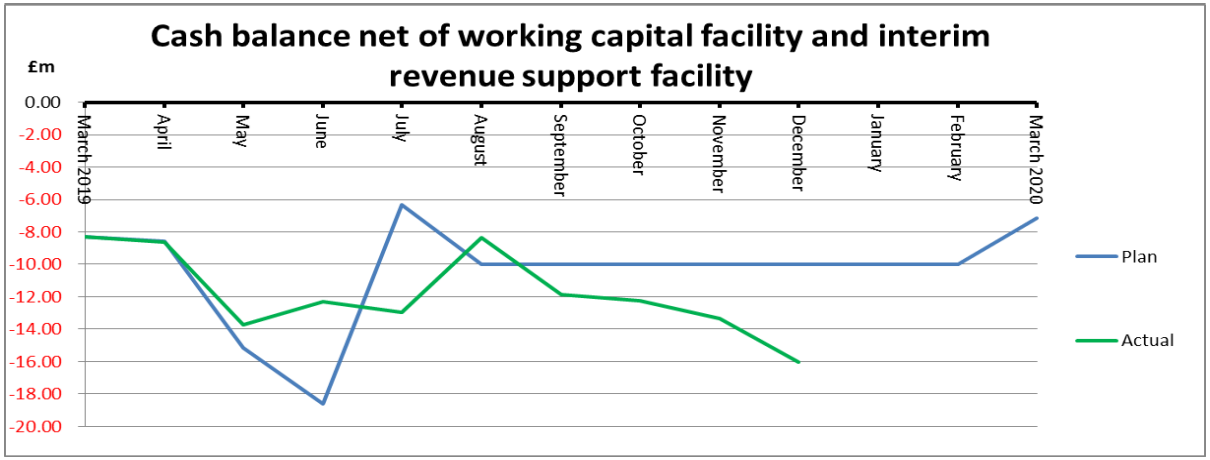
Year to Date £3.3m overspend.
Pay overspent £2.94m. CIP shortfall £0.9m, Senior Medical Pay (Care of the Elderly, Breast Care, Ophthalmology) £0.4m, Emergency Nursing and support staff £0.9m, General medicine locums, Acute Physicians and Junior doctors £0.4m, Acute and Community wards £0.5m, Rapid Response, reablement teams, other community services £0.4m. Pay underspends £0.5m (Theatres,Gastro, Head & Neck). Non pay overspend £0.2m. CIP shortfall £0.4m, overspend premises and other costs £0.2m, underspends £0.3m Surgical division phasing RTT funding in first part of the year. Contract income £0.2m adverse.

Forecast £5.1m overspend.
Pay overspend £4.0m. CIP shortfall £1.4m, Emergency bank /agency nursing £1.2m, Gen medicine locums, Acute physicians, Junior Doctors £0.6m, Senior Medical pay Care of the Elderly & Stroke £0.5m, Rapid Response, Reablement & Hospital team staffing £0.3m, Acute and Community wards £0.6m. Pay underspends mainly General surgery £0.3m. Non pay overspend £1.1m - CIP shortfall £0.8m, other non pay costs £0.3m.

	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget	Variance between Forecast and Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Torbay									
Income	178.01	3.10	181.10	180.42	(0.69)	239.89	236.65	240.76	(0.87)
Pay	(66.04)	(3.49)	(69.53)	(69.48)	0.04	(93.96)	(88.05)	(92.91)	(1.05)
Non Pay	(104.73)	(8.39)	(113.13)	(114.02)	(0.90)	(153.16)	(139.50)	(150.73)	(2.43)
Surplus / (Deficit)	**7.24**	**(8.78)**	**(1.55)**	**(3.09)**	**(1.54)**	**(7.23)**	**9.11**	**(2.88)**	**(4.35)**

Year To Date Compared to budget there is a **£1.54m overspend**. A main contributor is a £690K under recovery on **income** with the material factor being lower Torbay Council income than budgeted for (£1.5m). In addition to this there is an overspend of £900K on N**on Pay** which is materially in the Paignton & Brixham Locality and is driven by overspends in the Independent Sector on Adult Social Care 'packages of care', Cath Lab M&S equipment and Pacemakers.
Forecast - During the remainder of the financial year the Torbay position is set to deteriorate to an **overspend of £4.35m.**There is a forecast under recovery of **income** £0.87m (Torbay Council income £2.25m) and this is combined with a £1m pressure on **pay** which is driven by Medical Pay (Locum Costs), unachieved vacancy factor and ward overspends all predominantly in the Paignton & Brixham Locality. Finally **non pay** is set to overspend by £2.43m mainly due to cost pressures in the Independent Sector (Packages of Care impacted by volume & price issues covering both ASC and Health Placed People) combined with Cath Lab M&S Equipment and Pacemakers.

Cash



	Year to Date - Month 09			Previous Month YTD	
	Plan	Actual	Variance	Variance	Movement in Variance
	£m	£m	£m	£m	£m
Opening cash balance (net of working capital facility)	**(8.29)**	**(8.29)**	**(0.00)**	**(0.00)**	**0.00**
Capital Expenditure (accruals basis)	(14.77)	(7.14)	7.63	6.57	1.06
Capital loan drawndown	0.00	0.00	0.00	0.00	0.00
Capital loan repayment	(3.39)	(3.39)	(0.00)	(0.00)	0.00
Proceeds on disposal of assets	0.61	0.02	(0.59)	(0.61)	0.02
Movement in capital creditor	(1.22)	(1.86)	(0.64)	(0.68)	0.03
Other capital-related elements	6.45	0.35	(6.11)	(4.86)	(1.24)
Sub-total - capital-related elements	**(12.32)**	**(12.03)**	**0.29**	**0.42**	**(0.13)**
Cash Generated From Operations	14.01	7.45	(6.56)	(4.46)	(2.09)
Working Capital movements - debtors	1.22	(0.62)	(1.85)	(1.69)	(0.16)
Working Capital movements - creditors	1.42	2.99	1.57	2.30	(0.74)
Net Interest	(2.79)	(2.51)	0.27	0.27	0.01
PDC Dividend paid	(1.85)	(1.85)	0.00	0.00	0.00
Other Cashflow Movements	(1.25)	(1.51)	(0.26)	(0.20)	(0.07)
Sub-total - other elements	**10.77**	**3.95**	**(6.82)**	**(3.78)**	**(3.04)**
Closing cash balance (net of working capital facility)	**(9.85)**	**(16.38)**	**(6.53)**	**(3.35)**	**(3.17)**

Closing cash balance	1.15	6.00	4.85	5.68	(0.83)
Closing working capital facility	(11.00)	(11.00)	0.00	0.00	0.00
Closing interim revenue support facility	0.00	(11.38)	(11.38)	(9.04)	(2.34)
Closing cash balance (net of working capital facility)	**(9.85)**	**(16.38)**	**(6.53)**	**(3.35)**	**(3.17)**

Key points

The cash position is presented net of amounts drawn down from the working capital and interim revenue support facilities, in order to show the underlying cash position.

- Capital-related cashflow is £0.3m favourable. While capital expenditure is £7.6m favourable, a significant proportion of this would have been funded through non-cash methods such as finance leases (£5.3m adverse) and donations £0.6m (adverse). There are also adverse cashflows due to the paying down of the capital creditor £0.6m and delayed disposals £0.6m.

Other elements:

- Cash generated from operations is £6.6m adverse, due to EBITDA £6.6m adverse.
- Working Capital debtor movements is £1.9m adverse, primarily due to increased debtors with Torbay Council £4.9m, partly offset by income received earlier than planned.
- Working Capital creditor movements is £1.6m favourable, largely due to income received earlier than planned, including CCG £1.5m and winter pressures funding £0.5m.

Use of Interim Revenue Support facility

- The M09 position included cash balances and working capital loans both higher than planned. It was not feasible to offset the two, due to the inflexible nature of the working capital facilities.

Capital

Current Performance

	Year to date Mth 09			Full Year		
	Budget £m	Actual £m	Variance to Budget £m	Budget £m	Forecast £m	Variance £m
Capital Programme	12.81	7.14	(5.66)	19.57	18.74	(0.83)
Significant Variances in Planned Expenditure by Scheme:						
Trust Funding						
HIS schemes	1.97	1.59	(0.38)	5.40	5.22	(0.18)
Estates schemes	4.48	2.94	(1.54)	6.40	6.26	(0.14)
Medical Equipment	5.40	1.63	(3.77)	6.47	5.68	(0.79)
Other	0.00	0.00	0.00	0.00	0.00	0.00
PMU	1.50	1.03	(0.46)	2.13	1.63	(0.50)
Contingency General	0.00	0.00	0.00	0.00	0.00	0.00
Prior Year	0.00	(0.06)	(0.06)	0.00	(0.06)	(0.06)
Planned slippage	(0.55)	0.00	0.55	(0.83)	0.00	0.83
Total	12.81	7.14	(5.67)	19.57	18.74	(0.83)
Funding sources						
Secured loans	0.00	0.00	0.00	0.00	3.00	3.00
Unsecured loans	0.00	0.00	0.00	0.00	0.00	0.00
Strategic Estates P'sh	0.00	0.00	0.00	0.00	0.00	0.00
Finance Leases	5.80	0.73	(5.07)	6.51	5.57	(0.94)
PDC	0.46	0.27	(0.19)	0.93	3.01	2.08
Charitable Funds	0.75	0.77	0.02	1.00	0.21	(0.79)
Disposal of assets	0.00	0.00	0.00	0.90	0.30	(0.60)
Other Internal cash resources	5.79	6.07	0.28	10.23	6.66	(3.58)
Total	12.81	7.14	(5.67)	19.57	18.74	(0.83)

Key Points

- In April 2019 the Trust submitted a capital plan of £19.0m. In May 2019 the Trust submitted a revised capital plan of £21.6m.
- In July 2019, NHSI requested that the Trust propose a reduced capital plan - this was proposed at £16.6m. However, following an increase in national funding, NHSI abandoned this request. The Trust's official capital plan therefore remains at £21.6m but the Trust had adopted the £16.6m proposal as its capital budget. An additional £250k PDC funding for medical equipment was granted in October increasing overall budget to £16.8m. Further additional PDC Funding of £500k for Estates Project - patient flow and £265k for medical equipment and £40k for IT was granted in November. Also in November an additional £1.44m of exchequer funding for IT Projects was approved by the Trust and additional CFHD funding of £480k incorporated - therefore revised 2019/20 Capital Budget is at £19.57m.
- At 31st December, year to date capital expenditure is £7.14m; £5.67m underspent to budget (see table).
- The full year forecast is £18.74m. Between now and the end of the year, it is expected that we will spend £11.6m for the following schemes: purchase of high value medical equipment £4.1m, continuation of Theatres upgrade and refurbishment of £3.3m, material investment in IT of £3.6m namely purchase of PC's and upgrade of Microsoft licenses and Torbay Pharmaceutical (TP) equipment lease of £0.6m. The capital forecast is £0.83m less than approved budget principally due to slippage against projects. The projected year end spend is based on the assessment of project scheme leads and this is reviewed on a monthly basis. Any change is reported to the NHSI and the Trust Board.

Activity

setting	Annual Plan	YTD Plan	YTD Actual	Cumulative variance Current Month	Cumulative variance Previous Month	% variance to plan
Day Case	34,014	25,999	26,460	461	288	2%
Elective	3,640	2,885	2,754	-131	-136	-5%
Non-Elective Emergency	29,367	22,230	20,702	-1,528	-1,444	-7%
Non-Elective Non-Emergency	2,815	2,182	1,966	-216	-216	-10%
Non-Elective CDU	4,605	3,497	3,436	-61	-93	-2%
Non-Elective AMU	3,859	2,823	3,727	904	770	32%
TOTAL APC	**78,300**	**59,616**	**59,045**	**-571**	**-831**	-1%
New	107,867	81,886	79,286	-2,600	-2,510	-3%
F-Up	260,030	197,416	200,298	2,882	929	1%
TOTAL OPA	**367,897**	**279,302**	**279,584**	**282**	**-1,581**	0%
A&E	79,199	61,380	60,945	-435	-503	-1%

Activity variances to plan - Month 9

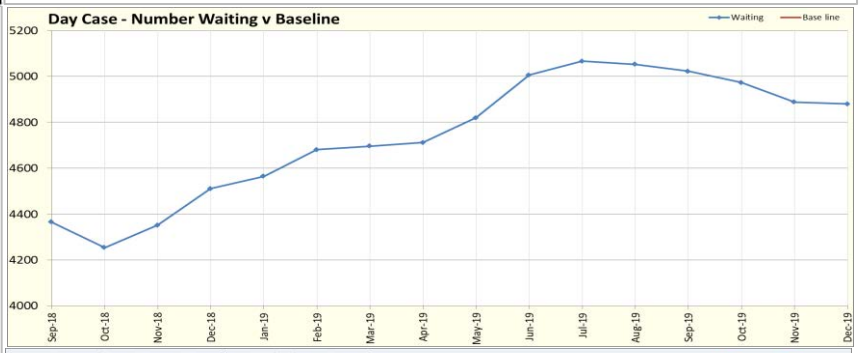
Activity variances for M9 against the contract activity plan are shown in the table opposite. In M9 Elective activity is behind plan. Non Elective Emergency activity is behind plan. AMU activity is above plan.
At treatment function level the greatest variance in elective activity is within T&O where activity is 120 attendances below plan (in PBR terms £386K).
Within Outpatients, the specialties with the greatest variances are, Respiratory Medicine which is 454 New attendances above plan (in PBR terms £110k), and Breast Surgery which is 334 attendances above plan (in PBR terms £55k). Vascular Surgery is 1,031 attendances below plan (in PBR terms £-97k), and T&O is 1,037 attendances below plan (in PBR terms £-90k).

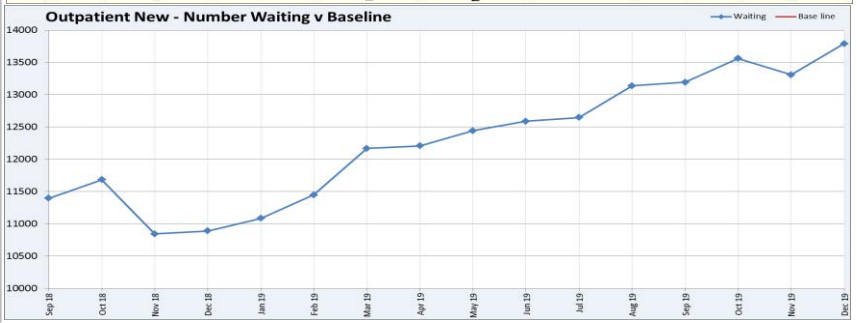
For Follow Ups, Cardiology is 1,022 attendances above plan (in PBR terms £146K). Audiology is 1,438 attendances below plan (in PBR terms -£158k).

The committee is asked to note: Month 9 Access standards.
Plans for 19/20 and beyond require overall increase in activity run rate to deliver waiting time access targets. The waiting list for new outpatients and Daycase procedures has seen significant increases. The high number of patients waiting remains a concern for delivery of access standards. Plans for 20_21 will be reviewed with teams to ensure sufficient capacity is built into plans to see these waits reduced to sustainable levels fro RTT delivery within the available funded resources.

We continue to forecast clearance of all patients waiting > 52 weeks RTT by 31st of March 2020.

The RTT risk and Assurance group are maintaining the elective waiting time (RTT and cancer) performance oversight at individual team level.
It is noted that new referrals for initial outpatient assessment over a rolling 12 month period are remaining at historical levels within 1% growth, however there is a large increase in the number referred on an urgent two week wait cancer pathway of 10% on the rolling year to date.





CIP Delivery: Current Month, Cumulative & Forecast

a) Current Month and Cumulative to Current Month Delivery against Target

Summary:

-Current Month variance: £0.5m shortfall

-Cumulative variance: £2.9m shortfall

The current month position shows CIP delivery of £1.5m, a £0.5m shortfall against £2.0m target.

In the year to date, the Trust has delivered £8.2m of savings, which is £2.9m adverse to the original plan. Of this, £2.6m has been delivered recurrently.

b) Year End Forecast Delivery against Target and Recurrent FYE forecast delivery

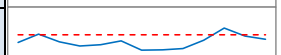
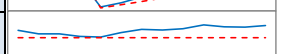
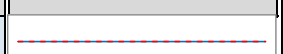
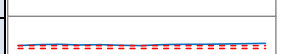
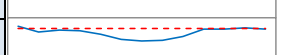
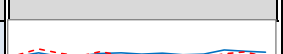
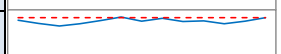
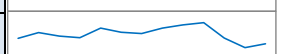
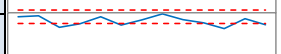
Target:	**£20.0m**
Year End Forecast Delivery:	**£10.3m**
Shortfall:	**£9.7m**

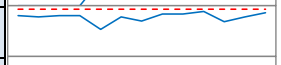
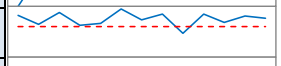
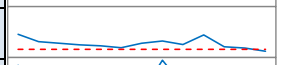
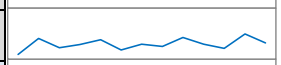
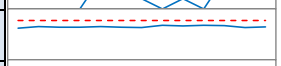
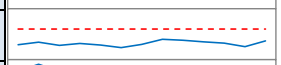
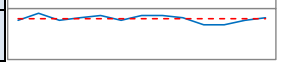
Target: The CIP target shown is £20.0m of which £17.5m is recurrent and £2.5m is Non-Recurrent.

A total of £10.3m of Forecast Out-Turn delivery has been identified, resulting in a £9.7m shortfall in FOT position. This represent a significant risk to the underlying financial performance and the opening position for next financial year.

Risk: Presumes all schemes listed on the register deliver.

	ISU	Target	13 month trend	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Year to date
QUALITY LOCAL FRAMEWORK																	
Safety Thermometer - % New Harm Free	Trustwide	>95%		96.9%	97.8%	96.4%	95.9%	96.3%	95.4%	96.8%	96.8%	97.3%	96.5%	96.8%	97.4%	96.1%	96.6%
Reported Incidents - Severe	Trustwide	<6		0	2	0	1	0	0	2	1	2	3	4	1	1	14
Reported Incidents - Death	Trustwide	<1		0	0	0	0	0	0	0	0	0	1	0	1	0	2
Medication errors resulting in moderate harm	Trustwide	<1		0	0	0	0	2	1	0	0	0	0	0	1	0	4
Medication errors - Total reported incidents	Trustwide	N/A		33	68	43	50	31	48	39	46	61	37	46	58	47	413
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		1	2	0	1	2	0	0	0	0	0	1	0		3
Never Events	Trustwide	<1		0	0	0	0	0	1	0	0	0	0	0	1	0	2
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		2	3	5	5	2	7	4	2	5	2	5	7	4	38
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	0	0	0	0	2	2	2	0	0	0	6
Formal complaints - Number received	Trustwide	<60		19	22	21	33	13	21	23	34	24	26	29	26	13	209
VTE - Risk Assessment on Admission (Acute)	Trustwide	>95%		92.0%	92.2%	89.4%	90.5%	89.2%	91.0%	90.7%	92.2%	90.1%	89.9%	92.2%	93.2%	91.7%	91.2%
VTE - Risk Assessment on Admission (Community)	Trustwide	>95%		97.9%	97.7%	97.8%	91.5%	98.9%	100.0%	97.5%	97.8%	98.7%	98.8%	95.3%	98.9%	97.6%	98.2%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		91.8	93.2	102	96.7	106.8	106.7	113.6	109.9	103.1	98.4				94.8
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		102.4%	103.8%	104.0%	104.0%	98.5%	91.7%	90.9%	90.1%	93.9%	90.4%	88.8%	89.6%	90.4%	91.5%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		101.4%	102.1%	103.2%	103.2%	98.5%	91.8%	93.7%	92.8%	100.3%	91.7%	91.6%	93.2%	91.7%	93.9%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		18	42	66	0	4	42	12	36	63	34	0	42	0	233
Hand Hygiene	Trustwide	>95%		95.0%	94.1%	95.8%	89.5%	92.2%	87.7%	93.8%	93.5%	95.2%	95.7%	96.1%	96.5%	93.9%	93.8%
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		70.0%	67.5%	80.0%	78.4%	50.0%	73.3%	62.5%	56.8%		51.6%				62.0%
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		85.5%	82.9%	89.1%	79.7%	93.8%	75.5%	79.1%	86.8%	80.4%	96.4%	87.2%	93.3%	84.5%	85.9%
Stroke - SSNAP level	Trustwide	N/A		B	C	C	C										
Follow ups 6 weeks past to be seen date	Trustwide	6400		6062	5378	5437	5899	6240	6459	6803	6906	7393	6793	6694	6725	7243	7243
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<3.8%		4.3%	4.6%	4.9%	4.2%	4.2%	4.2%	4.2%	4.3%	4.3%	4.3%	4.3%	4.4%		4.3%
Appraisal Completeness	Trustwide	>90%		79.3%	78.3%	79.6%	78.9%	80.0%	80.0%	79.0%	80.0%	78.0%	78.0%	77.3%	78.0%	78.5%	78.0%
Mandatory Training Compliance	Trustwide	>85%		90.8%	90.7%	91.2%	91.4%	89.5%	90.2%	90.9%	90.3%	90.8%	90.3%	90.6%	90.5%	90.4%	90.3%
Integrated Performance Report	Trustwide	10%-14%		9.9%	10.3%	9.6%	9.7%	10.7%	10.7%	10.8%	11.2%	11.2%	11.3%	11.4%	11.4%	11.4%	

	ISU	Target	13 month trend	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Number of Delayed Discharges (Community) *	Trustwide	<315		375	344	266	278	370	356	419	508	562	392	373	319	344	2980
Number of Delayed Transfer of Care (Acute)	Trustwide	<240		171	246	176	137	149	185	97	101	112	189	305	230	198	1138
Timeliness of Adult Social Care Assessment assessed within 28 days of referral	Trustwide	>70%		74.7%	74.8%	75.6%	76.1%	76.4%	77.0%	74.6%	77.0%	72.5%	71.1%	69.5%	68.9%	68.8%	69.5%
Clients receiving Self Directed Care	Trustwide	>90%		92.1%	91.4%	90.7%	91.7%	91.1%	90.8%	90.3%	90.3%	90.1%	89.6%	89.0%	89.0%	89.1%	89.0%
Carers Assessments Completed year to date	Trustwide	40% (Year end)		22.1%	23.7%	26.3%	29.3%	3.6%	7.8%	13.2%	18.6%	23.2%	26.7%	29.2%	28.4%	35.4%	29.2%
Number of Permanent Care Home Placements	Trustwide	<=600		627	615	615	605	602	619	631	629	634	648	641	640	645	641
Children with a Child Protection Plan (one month in arrears)	Trustwide	NONE SET		172	170	186		170	186	201	228	219	206	184	176		206
4 Week Smoking Quitters (reported quarterly in arrears)	Trustwide	NONE SET		192			300			54			109				54
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	NONE SET		5.4%			4.9%			5.6%			5.3%				5.6%
Safeguarding Adults - % of high risk concerns where immediate action was taken	Trustwide	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Bed Occupancy	Overall System	80% - 90%		90.7%	94.3%	94.7%	92.8%	93.9%	91.4%	90.5%	94.0%	95.3%	95.4%	95.8%	97.6%	98.6%	93.8%
CAMHS - % of patients waiting under 18 weeks at month end	Trustwide	>92%		93.7%	89.4%	90.8%	90.3%	87.6%	83.9%	82.6%	83.1%	86.0%	91.6%	91.6%	92.4%	91.6%	83.0%
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET						532	550	514	567	563	569	594	530	556	594
Intermediate Care - No. urgent referrals	Trustwide	113		157	189	156	164	184	189	179	188	173	178	216	205	195	1295
Community Hospital - Admissions (non-stroke)	Trustwide	18/19 profile		236	279	222	257	258	249	220	196	202	204	226	230	212	1552
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		87.6%	76.4%	79.8%	81.0%	79.1%	84.2%	80.3%	84.3%	79.4%	80.7%	82.7%	77.3%	77.9%	80.7%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		81.8%	82.2%	81.3%	81.2%	80.7%	81.8%	81.5%	81.1%	80.7%	80.4%	79.9%	80.0%	79.4%	80.6%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		80.6%	74.5%	69.6%	73.7%	79.9%	86.5%	78.8%	84.1%	77.8%	79.0%	74.0%	78.8%	85.4%	80.4%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		9.8%	12.0%	10.7%	10.1%	13.7%	12.1%	11.7%	13.6%	14.9%	15.7%	10.0%	6.4%	7.9%	12.0%
Dementia - Find - monthly report	Trustwide	>90%		96.3%	97.2%	86.3%	89.4%	96.1%	88.3%	93.3%	98.8%	93.4%	90.5%	85.1%	94.3%	88.7%	92.0%

	ISU	Target	13 month trend	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Number of Clostridium Difficile cases reported	Trustwide	<3						5	5	5	4	6	3	8	2	4	42
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		80.1%	77.9%	80.1%	79.9%	53.4%	77.7%	69.5%	83.4%	83.4%	88.2%	68.2%	77.9%	85.6%	76.3%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		97.8%	94.4%	61.6%	38.8%	50.3%	97.5%	98.9%	98.9%	98.7%	97.3%	91.6%	100.0%	97.5%	89.4%
Cancer - 28 day faster diagnosis standard	Trustwide				60.6%	67.4%	67.6%	65.2%	63.5%	63.6%	74.0%	73.3%	70.6%	71.8%	73.2%	71.1%	69.8%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		98.2%	96.5%	98.7%	96.2%	96.7%	99.5%	97.3%	98.4%	94.7%	98.5%	96.8%	98.1%	97.7%	97.5%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		100.0%	98.8%	98.4%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		100.0%	93.3%	97.1%	100.0%	98.6%	96.9%	100.0%	95.9%	98.4%	95.9%	95.9%	95.9%	95.2%	96.9%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		100.0%	93.3%	96.8%	96.0%	94.7%	97.1%	96.8%	100.0%	93.9%	93.8%	94.7%	95.0%	97.4%	96.0%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		92.9%	88.9%	100.0%	70.0%	93.3%	90.9%	92.9%	93.8%	100.0%	96.0%	86.7%	85.7%	100.0%	93.1%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			62	52	34	37	33	41	34	28	31	36	39	27	24	24
RTT 52 week wait incomplete pathway	Trustwide	0		74	90	92	82	71	59	83	84	105	89	79	69	71	71
On the day cancellations for elective operations	Trustwide	<0.8%		2.3%	1.5%	1.4%	1.2%	1.1%	0.9%	1.4%	1.6%	1.3%	2.2%	1.1%	0.9%	0.6%	1.2%
Cancelled patients not treated within 28 days of cancellation *	Trustwide	0		17	11	12	6	3	3	6	19	9	8	8	7	3	66
Number of patients >7 days LoS (daily average)	Trustwide			121.7	125.7	134.2	131.9	134.4	130.6	125.5	124.8	128.3	131.7	127.4	121.5	120.1	128.9
Number of extended stay patients >21 days (daily average)	Trustwide			28.0	27.7	31.2	27.4	31.7	29.7	26.6	29.8	29.0	35.9	34.3	28.0	23.1	31.0
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		84	251	156	198	148	61	83	81	137	90	47	104	113	864
Ambulance handover delays > 60 minutes	Trustwide	0		4	23	8	9	13	11	4	5	12	2	5	13	14	79
A&E - patients recorded as >60min corridor care	Trustwide			184	532	328	423	430	319	424	384	447	416	382	494	463	3759
A&E - patients with >12 hour visit time pathway	Trustwide			44	201	110	142	190	90	146	123	212	146	103	247	158	1415
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		4	7	3	3	11	0	0	0	0	0	0	1	3	15
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		2	2	1	1	2	1	4	4	5	3	5	1	3	28
Number of Clostridium Difficile cases - (Community)	Trustwide	0		0	0	0	0	3	4	1	0	1	0	3	1	1	14
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		62.1%	64.9%	64.0%	63.6%	64.7%	63.9%	62.8%	67.3%	66.5%	67.4%	66.6%	63.1%	64.3%	65.2%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		29.5%	34.6%	27.9%	31.6%	29.1%	23.9%	30.0%	39.9%	38.2%	35.0%	32.6%	25.8%	36.8%	32.2%
Chig letters timeliness - 7 specialties within 4 working days	Trustwide	>80%		77.3%	90.9%	77.3%	81.8%	86.4%	77.3%	86.4%	86.4%	81.8%	68.2%	68.2%	77.3%	72.8%	79.5%

	ISU	Target	13 month trend	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
Capital Service Cover	Trustwide	2		4	4	4	4	4	4	4	4	4	4	4	4	4	
Liquidity	Trustwide	4		3	3	3	3	3	3	2	2	3	4	4	4	4	
I&E Margin	Trustwide	1		4	4	4	4	4	4	4	4	4	4	4	4	4	
I&E Margin Variance from Plan	Trustwide			2	2	3	3	4	3	1	2	2	1	2	2	3	
Variance from agency ceiling	Trustwide	1		3	3	4	4	4	4	4	4	4	4	4	4	4	
Overall Use of Resources Rating	Trustwide			3	3	4	4	4	4	3	3	3	3	4	4	4	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-1292	-2370	-5812	-7157	-6072	-925	-72	-1447	-1363	-473	-3022	-4464	-6555	
Agency - Variance to NHSI cap	Trustwide			1.04%	1.09%	1.21%	1.24%	1.42%	1.21%	1.23%	1.14%	1.17%	0.98%	1.03%	1.06%	1.07%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide			1150	-682	-6774	-8426	-628	-1191	-1296	-891	-239	-342	-1584	-2357	-2872	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			8854	11808	-14484	-12019	48	501	893	1146	2637	3301	4420	6559	7632	
Distance from NHSI Control total (£'000's)	Trustwide			-1159	-2292	-5722	-7096	-4861	-1213	91	-1248	-1019	58	-1651	-2833	-4616	
Risk Share actual income to date cumulative (£'000's)	Trustwide			599.5	2291	7624	7950	0	0	0	0	0	0	0	0	0	
ACTIVITY VARIANCE vs PREVIOUS YEAR																	
Outpatients - New	Trustwide			3.1%	2.5%	2.3%	2.5%	-2.4%	-0.4%	-1.8%	0.2%	-1.2%	-1.0%	-2.4%	-3.4%	-3.4%	-3.4%
Outpatients - Follow ups	Trustwide			3.8%	4.0%	4.2%	4.9%	1.2%	0.9%	0.9%	1.9%	0.8%	1.5%	1.1%	0.7%	1.2%	1.2%
Daycase	Trustwide			7.6%	8.4%	8.9%	10.5%	5.6%	7.9%	4.0%	4.0%	2.9%	3.8%	2.5%	3.1%	2.8%	2.8%
Inpatients	Trustwide			0.1%	2.0%	2.5%	3.8%	2.9%	-1.6%	-4.2%	-3.0%	-0.6%	-1.7%	-2.2%	-0.3%	2.0%	2.0%
Non elective	Trustwide			-0.7%	-1.4%	-1.9%	-2.3%	-1.8%	-0.9%	-2.9%	-3.5%	-4.5%	-3.4%	-2.3%	-1.7%	0.1%	0.1%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			314	367	311	311	366	331	355	358	339	380	395	380	382	
Intermediate Care GP Referrals	Trustwide			89	97	94	78	108	86	96	96	81	87	97	81	88	
Average length of Intermediate Care episode	Trustwide			16.505	17.514	13.873	14.536	16.261	16.175	11.953	16.598	18.976	15.503	14.653	13.482	14.619	
Total Bed Days Used (Over 70s)	Trustwide			9985	11768	9813	10430	11716	10385	9945	10191	10508	10440	10523	9919		
- Emergency Acute Hospital	Trustwide			5857	6777	5795	5938	6920	6336	5759	5911	5856	5776	6181	5916		
- Community Hospital	Trustwide			2939	3325	2903	3239	3133	2756	3031	2913	3366	3295	3180	3100		
- Intermediate Care	Trustwide			1189	1666	1115	1253	1663	1293	1155	1367	1286	1369	1162	903		

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Staff Experience Report			Meeting date: 5th February 2020
Report appendix	Appendix 1: Staff Experience Action Plan Appendix 2: Workforce Race Equality Standard Appendix 3: Workforce Disability Equality Standard		
Report sponsor	Director of Workforce and Organisational Development		
Report author	Workforce and Organisational Development Business Partner		
Report provenance	People Committee 3rd February 2020		
Purpose of the report and key issues for consideration/decision	To update the Board on the activity and plans to improve staff experience.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	To note the content of this report.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	x	**Valuing our workforce**	x
Improved wellbeing through partnership	x	**Well-led**	x

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework		**Risk score**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	**x**	**Terms of Authorisation**	
NHS Improvement	**x**	**Legislation**	
NHS England	**x**	**National policy/guidance**	**x**

Articulate any risks and implications arising from this report.

Report title: Staff Experience Report		Meeting date: 5th February 2020
Report sponsor	Director of Workforce and Organisational Development	
Report author	Workforce and Organisational Development Business Partner	

1. Introduction

1.1 This report seeks to provide an update to the Board on the activity taking place to improve staff experience (including equality, diversity and inclusion)

2. Background

2.1 A specific Engagement and Communication strategy and work plan was developed in 2017 for the ensuing two years. This is now complete and has been superseded by; a communications and engagement plan - focused on the development of the organisations strategy, and a wider staff experience plan - both of which are brought together in the development of the organisations People Plan.

2.2 The National Interim People Plan identifies staff experience as a fundamental pillar in making the NHS a Great Place to Work. This is key not only to recruitment and retention but to the associated benefits of increased morale, innovation, productivity and in turn patient experience and outcomes.

3. Infrastructure and Governance

3.1 The Trust has recently established a staff experience network which is co-chaired by the Trusts Health and Wellbeing Lead and Medical Consultant Lead for Staff Experience. The network includes representation from facilities, therapies, community, nursing and the mental health forum, with social care representative identified to join in the near future. The Trusts equality and diversity lead is also part of the staff experience network which ensures a connection with the Trusts Equality Business Forum (EBF) – recognising that both agendas are intrinsically linked.

3.2 The purpose of the staff experience network is to regularly review staff experience data/feedback, in order to develop appropriate actions to improve staff experience. Recognising that any singular data source is unlikely to reflect an accurate picture, multiple data sources are reviewed including; national NHS staff survey, internal doctors wellbeing survey, national health and wellbeing framework and local absence data. Appreciating the need to capture staff feedback at each point of the employee journey, data is also reviewed from the starter questionnaire - which has recently been reviewed and updated by the network, staff friends and family test, and leavers survey.

3.3 The Trust's Staff Experience action plan can be seen in *appendix A.* The network meets monthly and is scheduled to review the early findings from the 2019 national NHS staff survey in February. Following which the plan will be reviewed and updated.

3.4 The EBF is an established forum with representatives from protected groups including BME, LGBT and disability, together with a younger persons representative, faith & belief representative, staff side, international nurses co-ordinator and diversity and inclusion guardian.

3.5 The terms of reference of the forum have recently been reviewed and updated to reflect the purpose of the group which is to regularly review equality and diversity data/feedback, and to take a key role in developing appropriate action plans to progress the agenda. Due to national reporting requirements historically there have been multiple action plans. However, to enable the forum to undertake their role effectively, these plans are being reviewed and amalgamated into a singular plan (encompassing performance data) enabling clear priorities to be agreed and resources to be focused. The commonality across the WRES and WDES indicators further supports this approach.

3.6 Both the staff experience network and EBF submit regular reports to the People Committee.

4 Key Updates

4.1 Workforce Race Equality Standards

4.1.1 Since its introduction in 2015, the WRES has required NHS trusts to annually self-assess against nine indicators of workplace experience and opportunity, and to develop and implement robust action planning for improvement. Appendix 2 details the Trusts current performance against these standards. (The findings from the 2019 NHS Staff Survey are expected at the end of January following which the action plan will be reviewed and re prioritised if appropriate)

4.1.2 Research shows that organisations that have diverse leadership are more successful and innovative than those that do not. Employees who feel valued are more likely to be engaged with their work, and diversity at senior levels increases productivity and efficiency in the workplace. Such organisations are better placed to reduce health inequalities of our diverse communities and leads to better patient care, satisfaction and outcomes.

4.1.3 The overall BME workforce in the NHS is increasing, however this is not reflected at senior positions where there is an acute under-representation of BME staff and therefore this has been identified nationally as an area that requires accelerated support. Trust' have been set aspirational goals to increase BME representation at leadership levels, and across the pipeline by 2028. Work is underway with our recruitment team to explore different ways of advertising to attract underrepresented groups to apply to the Trust.

4.1.4 Recognising and harnessing the diverse talent we have available will be supported by our talent management strategy. The Devon High Potential Scheme is due to be piloted by the Trust this year, however it is recognised that for this to have any significant impact on improving under-represented groups there needs to be a feeder pipeline into the scheme.

4.1.5 In order to ensure leaders have the skills and knowledge to manage a diverse workforce the Trust's leadership training and managers' passport will be designed to have diversity and inclusion elements within the content.

4.1.6 In terms of improving the likelihood of BME staff accessing non-mandatory training, targeted promotion is planned. This in part will build upon the experience of the EBF's BME representative who is attending the national stepping up programmes this year.

4.1.7 Whilst the 2018 NHS Staff survey data suggested that there has been some improvement in the percentage of staff experiencing bullying, harassment or abuse (BHA) from staff, this was identified as an area of improvement for all staff - as for nearly a quarter of all staff to experience such behaviour is unacceptable. Improvement work this year has included the development of staff training which is focused on self-identification, encouraging staff to identify when they are feeling under pressure and stressed and the behaviour this can lead to. The training identifies strategies and signposts to support, whether they are behaving in a negative way or are experiencing bullying behaviour. This inclusive approach aims to ensure all staff feel supported by our organisation. This training is now delivered in induction and will be part of mandatory training as of February. In addition, the Trust has introduced a network of anti-bullying advisors, who act as a first point of contact for anyone who has experienced or witnessed any form of behaviour that causes them concern. A pre-launch session has been held with the network and a promotional plan is being implemented, with a planned launch in March. Still of concern is the 26% of BME staff who experienced abuse from patients, relative or the public. The Trust's Zero tolerance of abuse against all staff will require focused attention this year.

4.1.8 Of concern is the significant gap between white and BME staff on the percentage believing the Trust provides equal opportunities for career progression and experiencing discrimination. This will be a priority for improvement this year, should the national staff suggest this remains an area of concern.

4.2 Workforce Disability Equality Standards(WDES)

4.2.1 The WDES was launched in 2019 and requires the Trust to annually self-assess against 13 indicators of workplace experience and opportunity, and to develop and implement robust action planning for improvement. Appendix 3 details the Trust's current performance against these standards.

4.2.2 As can be seen there is clear commonality between the WRES and WDES indicators, therefore a number of the actions taken are expected to improve both agenda's, and the wider staff experience. This has further supported the amalgamation of the equality and diversity action plans into one focused document.

4.2.3 The Trust has signed up to the Disability Confident Scheme. The aim of the scheme is to support organisations to successfully recruit and retain disabled people and those with long term conditions. By signing up to the scheme we have committed to:

- Actively attract and recruit disabled people
- Provide a fully inclusive and accessible recruitment process
- Offer an interview to disabled people who met the minimum criteria for the job
- Be flexible when assessing people so disabled job applicants have the best opportunity to demonstrate that they can do the job
- Proactively offer and make reasonable adjustments as required

Work is underway with recruitment to review how we currently support disabled staff to apply to the Trust and how we can progress and gather evidence to level 2.

4.2.4 One of the key actions this year is to develop a marketing strategy to actively improve non-disclosure rates on protected characteristics. This will have two primary focuses – one, being to ensure staff are aware of the support available to them and the second, being about enabling more targeted communication so that the Trust can engage and learn from the experiences of staff with protected characteristics.

4.2.5 Focused work is underway to ensure reasonable adjustments are considered and monitored consistently across the Organisation for staff who have a disability/long term condition, to aid the retention of our skilled workforce. This has included the development of a reasonable adjustment policy, which will be launched in March. As part of the build up to the launch a reasonable adjustment film has been developed and presented at Trust Talk. The film seeks to communicate the importance of reasonable adjustments, through a number of staff sharing their stories about their disabilities and the reasonable adjustments that have been made to support them in work. Training to support the launch of the policy is currently being planned.

4.2.6 Of concern is the significant gap between disabled and non-disabled on the percentage of staff satisfied with the extent to which the Trust values their work and pressure to come to work despite not feeling well. These are two areas we would want to undertake targeted engagement with staff, following the work to improve non-disclosure.

4.3 Health and Wellbeing

4.3.1 This update seeks to build upon developments reported in December. The key highlights are taken from the Staff Experience Action Plan and are implemented in conjunction with others through the Staff Experience network

4.4 Emotional and Mental Wellbeing

4.4.1 Following successful courses in 2019 and at the request of staff, an event has been organised in January for all staff who have attended the HOPE (Help Overcoming Problems Effectively) program. This will review how staff have used skills and tools from the course to improve or maintain wellbeing. Feedback collected from this session will help to formulate future development of the HOPE programme through 2020.

4.4.2 A bespoke mental health awareness and support workshop was developed this year for F1 and F2 Doctors. Following positive feedback, the course will run again this year and has been updated to respond to this year's feedback.

4.4.3 A new critical incident debriefing response team (Jigsaw) has been brought together to support staff and teams who have been through an event that has created distressing thoughts and feelings that need to be addressed. The service is still developing, but has already responded to 7 calls from teams with excellent feedback. The referral pathway has been developed with a dedicated e-mail which is monitored 24hrs a day. Promotional materials are also being developed. The full service is expected to be fully functioning with referral pathway and defusing training from the end of February. Plans are also emerging around the development of a 'hot debrief' for child deaths.

4.5 Financial Wellbeing

4.5.1 Financial wellbeing is an emerging strand to the wellbeing agenda and one which recognises the significant adverse impact on colleagues productivity and mental wellbeing brought on through stress and anxieties relating to a colleagues personal financial situation; whether that be a lack of financial education, bad debt, mortgage arrears or simply the inability to meet their own/families financial day to day needs.

4.5.2 Locally the Trust's own Workforce and OD team has had conversations with colleagues, and supported by UNISON representative feedback, who say that their financial worries have led to mental health issues, anxiety and increased stress levels which have affected their overall wellbeing and a personal sense of reduced productivity and presenteeism.

4.5.3 Employers have a unique position to offer ways that may help colleagues manage their money better, not only to bring about tangible business benefits such as higher productivity, better job performance and lower absenteeism, but because ethically it's the right thing to do.

4.5.5 The Trust currently offers some financial support and advice in the form of its Employee Assistance Programme (EAP) and Hardship policy. The Trust also offers a comprehensive range of staff benefits - however it has become clear that many staff are unaware of these benefits.

4.5.6 A small task and finish group has been formed to 1. Review and update the Staff benefits offer, including its promotion 2. Explore the procurement of a financial wellbeing provider to help staff create better financial habits through education, financial tools, and savings and investments.

4.6 Physical Wellbeing

4.6.1 The flu campaign for 2019/20 set a target for 80% of clinical frontline staff to receive the flu vaccine. Currently, 59.99% have received the vaccination, compared to 54% at the same time last year. The campaign will conclude at the end of February.

4.7 Value and Recognition

4.7.1 There is a desire from staff across the Trust to see the introduction of Long Service Awards to recognise and celebrate service. 'Just Ask' questions are regularly submitted by people from across the organisation asking why we do not at the present time have these awards. People are using the 'Staff Hero Awards' as a vehicle for long service recognition, which is not appropriate and it is felt that this needs to be addressed. A discussion paper has been presented to the Senior Workforce and OD Team and will be taken to the People's committee in February 2020. It is felt that by introducing these awards it will support our work to:

- Improve staff retention
- Value staff
- Celebrate a sense of pride
- Improve wellbeing

4.8 Communication

4.8.1 Storytelling Workshop – In response to a well-attended Storytelling workshop during our Health and Wellbeing week it was felt that this powerful form of communication needed to be explored in a wider context. Communication, in many areas, has been identified as challenging and this innovative form of sharing can create the right environment for enabling staff and patients to communicate the most personal and important aspects of their health and health care. The workshop will be scheduled for end February/March and will have an open invitation to those who feel that this will support them to increase engagement and inspire good communication in times of change.

4.8.2 The introduction of various new staff support initiatives over the last 6 months has highlighted the need to communicate this to ALL staff across the Organisation. As a group we are very mindful that we have staff based across Devon and that there are challenges in ensuring that our communication reaches staff in a variety of mediums. As part of this we have plans to provide a 'Roadshow' to take support and information out to all areas.

5. Recommendation

The Board is asked to note the contents of the report

Act No	Action	Action assigned to	Deadline	Progress
	Scope of Action Plan The action plan detailed below has been developed by a multi- disciplinary team and seeks to respond to a review of the following staff experience data; Sickness absence data, 2018 National Staff Survey findings, Completion of the National Health and Wellbeing framework, Completion of the National Health and Wellbeing framework, Qualitative information gained from 1-1 discussion with staff who have been absent as a result of mental ill health. The draft action plan will be shared with staff and other key agencies including; Optima, Lifestyles team and SBMT for further development. Progress against the action plan will be monitored through Workforce and OD Group.			
	Section A			
	1.0 ENABLERS- Board Leadership			
1.1	Identify NED and Clinical Exec Director to sponsor Health and Wellbeing agenda.	Judy Falcao	28/02/20	Medical Directorate to share sponsor role with DoW. Proposal to be developed about the appointment of a Wellbeing Guardian (as a NED) in accordance with HEE Mental Health Commission report
1.2	NED and Exec Director' to visibly demonstrate the Boards support and commitment to H&W agenda through regular feedback, board objectives, sharing vision, personal experiences/stories.	Judy Falcao/Rob Dyer	28/02/20	Medical wellbeing survey presented to May board - subsequent meetings arranged with Execs to progress actions and to develop communication updates to staff, to include data on performace, pressure in the system, quality of care and patient feedback. Encourage stories being fed back via comms eg small acts of kindness.
1.3	People Strategy to include Health & Wellbeing/Staff Experience as a central pillar, underpinned by this action plan with 6 monthly report to Board	Sarah Lehmann	31/01/20	People committee will oversee the development of the People Plan in line with the national plan. A framework for the creation of the plan is to be presented to the People Committee on 9th Dec where the approach for engaging with key stakeholders will be discussed.
	2.0 ENABLER – Training and Awareness			
2.1	Review of management training to ensure adequately equip managers with the skills to identify, manage and signpost to H&W support as required.	Trudi May	31/01/20	Based upon early information 'Having That Conversation' (Mental Health awareness) management training has been developed and rolled out after a successful pilot. This training is also forming a major part of a digital project currently under development for across the STP. Review of current Resilience training ongoing.
2.2	Review of Health and Wellbeing Training for staff	Trudi may	31/01/20	Based upon early information a half day awareness MHFA course has been developed and piloted. A 1hr workshop on Looking after your colleagues has also been piloted. A paper has been written and submitted to staff experience group with options around the future provision of MHFA training. New story based e-learning package being designed based on 'having that conversation'. Working with Horizon Digital to produce a 20 min interactive learning experience.Further engagement planned with teams about 'resilience' training and how courses are delivered e.g. 1 hour bite size Sessions or half dav workshops.
2.3	Regular provision of 'Managing attendance' training/workshops	Kathryn Chidzey-Jones	28/06/19	Training delivered upon request. Regular provision is part of management training plan for 2020.
2.4	Induction to include the Trusts commitment to Health and Wellbeing – resources, prevention, identifying/recognising if struggling	Trudi May/Maria Saunders	27/03/20	Initial conversation held to review current content of induction which has identified minimal reference to H&W. Further meeting to be scheduled to discuss key messages to convey and develop appropriate materials. Scope whether there is a need to review local induction to maximise health and wellbeing conversations. Wellbeing is now part of Junior Dr induction and a support booklet has been issued to all Junior Drs.
2.5	All managers to have a set objective on Health and Wellbeing	Judy Falcao	31/01/20	Dir of WF and OD to take proposal to EDs
2.6	Develop support networks for managers and staff - action learning, mentoring, coaching	Chris Edworthy	31/08/19	Coaching collective network of coaches has expanded to over 40 coaches that all staff have access to (over 300 requests for coaching received so far). Expanding network of mentors to commence in March 2020. Use of action learning sets linked to existing leadership programmes with limited success. Review in line with Managers Passport and offer
2.7	Capture and share data and stories about reasonable adjustments to support learning.	Debbie maynard	31/10/19	Presentation to Trust Talk in December on reasonable adjustments To include stories and short videos from disability enablement group
2.8	Centralised platforms to communicate Health and Wellbeing offer (training, support, case studies) to improve visibility and ease of access. To include – dedicated web pages, noticeboards, app, closed facebook group	Trudi May/Paul Norrish Julie Southam		As a test of change Wellbeing noticeboards have been procured for 10 ward - baseline data has been established to determine any improvement in awareness of wellbeing offer. New staff Wellbeing Board positioned close to the entrance of Bay View Restaurant. Closed facebook group developed and advertised. New web pages developed - content will be regulated from staff input and through SE group and mental health forum. Representation from staff experience group on Trust intranet working group.
2.9	Occupational Health to meet with groups of staff to promote their offer – sharing stories etc	Chris Edworthy	19/06/19	Ran sessions during health and wellbeing week in June. HRAs actively promoting EAP with managers and staff.
2.1	Develop communication/promotional plan for health and wellbeing offer, to include Devon initiatives.	Trudi may/Paul Norrish	31/12/19	Draft calendar for health and wellbeing discussed and agreed - displayed on wellbeing pages. Individual posters/screensaver messages/tweets and facebook messages to be displayed for individual events.
2.11	Develop mess welfare rep role to include junior doctor wellbeing and training to become speak up champion	Maria Saunders	06/12/19	Welfare reps in place and will become Anti-Bullying Advisors. Three Junior Doctors identified as FTSU Champions
2.12	Monthly sessions with F1s & F2s around wellbeing	Maria Saunders	27/09/19	Complete. Mental health first aid course available to foundation trainees and a half day wellbeing session will be conducted for F2s in March.
2.13	Develop a new consultant programme to encourage networking, develop leadership skill and wellbeing strategies for the consultant and their teams	Maria Saunders	31/05/19	Complete
2.14	Awards - staff heroes / learning from excellence	Maria Saunders / Judy Falcao	31/01/20	Expanding engagement with local and hospital wide awards. Encouraging local areas to use LfE and staff heroes. Need to feed into comms
2.15	Scope out what the offer could be to senior staff members around support eg coaching offer to all, possible pastoral support for seniors etc	Maria Saunders / Chris Edworthy / Judy Falcao	31/01/20	Discussions had with appraisal lead, agreed in principal that this would be a good idea.
	3.0 Engagement and Data driven decision making			
3.1	Use specific wellbeing surveys and conversations	All		Medical Wellbeing survey completed– Consultant SE Lead fed back to Board in May and has presented to specialties in order to increase recognition and to gain suggestions. Individual conversations with those staff who have suffered from mental ill health are ongoing. Roundtable discussion on bullying held in May from which an action plan has been developed.
3.2	Undertake 'Big Conversations' to gain staff feedback on improving those areas identified for development in NSS	Jenny Shepherd	30/06/19	Complete - Honest conversation pilot completed with de-brief session and summary feedback issued to teams that participated. Decision to continue with conversations on a bi-annual basis.
3.3	Pilot 'Great place to work survey' as a means of continuous improvement.	Julie Southam/Jenny Shepherd		Complete and ongoing. Midgley Ward is piloting. Data collection during the month of April. Findings published together with actions and proposed test of change which commenced end Aug. provisional plan to repeat survey in April to measure impact. Survey now being used in Podiatry.
3.4	Review H&W interventions to ensure job role is captured, an evaluation is completed and appropriate data/metric is identified to track impact. Responding to data as appropriate	Trudi May	27/03/20	Work has already commenced to ensure the relevant data is being captured for each of our interventions. Quarterly uptake report to be developed to summarise usage by staff group.
3.5	Ensure the H&W plan is visible to staff with an opportunity for them to contribute to its ongoing development. (wellbeing week to launch, noticeboards)	Trudi May	31/05/19	Discussed and included in SBMT minutes for attendees to share with teams.
3.6	Develop hub and spoke staff experience group to aid sharing of information	Trudi May		Trust Staff Experience network established.
	4.0 MENTAL HEALTH			
4.1	Train a network of staff in 'Critical Incident Support and Management' to provide support to staff and team post a difficult incident	Trudi May	31/07/19	Complete - CISM Training complete and network established.
4.2	Development of reflective practice and supervision	Chris Edworthy	31/01/20	To align with Managers Passport approach recommending as best practice.
4.3	Continue to develop a network of mental health first aiders to provide support to managers and staff	Trudi May	15/07/19	List of those attending the full 2 day course have been compiled. Course details have been changed so that those who complete MHFA 2 day will be mental health first aiders. Initial Network of mental health first aiders established and advertising resources under development
4.4	Clear concise guidance of what support different agencies can offer and their target audience in order to manage expectations	Debbie maynard/Optima	31/02/2020	
4.5	Introduction of pop up schwartz rounds. Continued development of main Schwartz Rounds to increase robust	Maria Saunders/Trudi May/ Sarah Blacoe		Complete and ongoing- Pop Up Schwartz have been piloted in acute medicine and gastroenterology and not considered terribly successful. As such alternatives approached are being considered. Main Schwartz rounds continue on a monthly basis, with variable attendance of between 7 and 50 influenced in part by the OPEL status.
4.6	Review staff communication (and decisions to stand down activities) in OPEL 4	Maria Saunders	02/12/19	Amended message now being issued. Further work planned about assessing impact of the message to inform future recommendation. Discussions had with execs around evaluating what is needed and adopting a more targetted communication, if appropriate.
	5.0 MSK			
5.1	Review of physical activities currently offered to support gap analysis and promotion.	Becci Brixton	31/12/19	Initial scoping complete with minimal activity identified. Promotion of 'Lets Walk' Devon (Active Devon) aimed at the workplace will be supported, with the launch starting in February 2020. A desk based stretching and exercise sheet with workplace mindful tips is under review prior to circulating to all staff and for use as screen savers.
5.2	Explore fast track physio for all staff (even those that do no live in the Torquay area)	Chris Edworthy	31/12/19	Initial scoping complete - capacity issues means physio are unable to extend offer an support staff without a Torbay/SD GP. Explore as part of tendering for OH contract.
5.3	Introduce lunch time walk	Trudi May	10/06/19	Work ongoing with Estates looking at improving and making safe the Woodland walk. As above promotion of 'Lets Walk' Devon will highlighted with the launch in February
5.4	Ensure appropriate infrastructure to support physical activity i.e shower/changing facilities.			
	6.0 LIFESTYLES			
6.1	Explore the opportunity to appoint a GP to undertake staff health checks/MOT's.	Maria Saunders		Complete - Discussed with Board in May – support to explore further. Further discussions had - this is not possible.
6.2	Identification and development of wellbeing spaces	Chris Edworthy	31/10/19	Wellbeing room identified within Horizon Centre - regularly used. Lesley Darke reviewing further options including a pod in the front entrance – Judy following up.
6.3	Review out of hours provision for healthy hot and cold food	Trudi May	30/09/19	Review of food provision will be focused through Nutrition Steering Group Ist meeting on 19/6/2019. Jnr Dr Funding to be used in part to purchase hot food vending machine, which will be accessible to all staff (see action 6.8)
6.4	Development of joint working with Reserve Army Field Hospital.	Trudi May		Initial Steering Group Meeting 13 May. This is a three pronged plan to: Engage with staff to encourage becoming reservists; Encourage employment; Ensure service personnel have equality in access to treatments. Main focus of work was signing the new Charter which happened at an event on Tues 11 June. Jon Beake attended a forward planning meeting to support us attain silver accreditation (bronze already achieved). Military Challenge weekend in September 2019 was represented by a team from ED. Future military challenges will scheduled for March and September 2020
6.5	2019 – 2010 Flu Campaign CQUIN target 75%. Look to increase total % by 10% (?)by normalising rather identify as a campaign.	Trudi may /Sarah Blacoe	30/09/19	See Flu action plan.
6.6	Plan and launch Health, Wellbeing and Kindness Week	Trudi May/Sarah Blacoe	30/06/19	Complete
6.7	Review staff benefits including promotion.	Anna Pryor	31/01/20	A small group has been formed to review the staff benefits and create an action plan for promotion through 2020. Group has met twice and is progressing a review and update of those benefits already listed to ensure that they are current. In addition, research has started into providing staff with an option of financial support to run alongside the staff benefits
6.8	BMA Fatigue and Facilities Charter formally adopted by the Trusts medical JLNC for Jnr Drs and used to inform the way the allocated funding is spent	Maria Saunders/Kelly Ebdon-Marks/ Anna Alexander		Change in car parking permits enables those who live within 2 miles but work and travel after 10pm to park on site. Sleep facilities are available for trainees free of charge who are resident on call at night. Facilities are also available for doctors who are too tired to drive home after a shift. JLNC proposal has been written and awaiting approval. There are plans to redesign space to expand this area to offer two seperate rooms to sleep. There are some plans for specific work areas but the main developments focus on the mess.
	SUPPORTING ACTION PLANS			
	Speak Up Work programme - owner Sarah Burns WRES and WDES action plans - owner Debbie Maynard Self organising teams – owner Sarah Lehmann Anti-bullying roundtable Improving junior doctor support - Maria Saunders			

Appendix 2

Workforce Race Equality Standard (WRES)

WRES Standards	2017 (18)		2018 (19)	
	White	BME	White	BME
1. %of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the % of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	See Annual Workforce Report .			
2.Relative likelihood of staff being appointed from shortlisting across all posts	1.34 more times likely for white staff to be appointed		0.76 more likely for white staff to be appointed	
3.Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	No more likely for BME staff to enter the disciplinary process than white staff		It was no more likely for BME staff to enter the disciplinary process than white staff	
4. Percentage difference between the organisations Board voting membership and its overall workforce	7%	-4.9%	7.2%	-5.7%
5. Relative likelihood of BME staff accessing non-mandatory training and CPD compared to white staff		0.92%		0.80%

Data taken from ESR

WRES Standards	2017 (18)		2018 (19)			
	White	BME	White	N/A	BME	NA
6.% Believing trust provides equal opportunities for career progression or promotion	85%	73%	86%	87%	77%	74%
7.% staff experiencing harassment, bullying from relatives or public in last 12 months	23%	25%	22%	26%	26%	27%
8.%Staff experiencing harassment, bullying or abuse from staff in last 12 months	22%	26%	23%	24%	24%	29%
9.In the last 12 months have you personally experienced discrimination at work from any of the following manager/team leader/other	7%	17%	7%	6%	17%	15%

Data taken from National Staff Survey

Appendix 3

Workforce Disability Equality Standards (WDES)

WDES Standards	2018 (19)	
	Disabled	Non Disabled
1.% of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the % of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	See Annual Workforce Equality Report.	
2.Relative likelihood of staff being appointed from shortlisting across all posts	0.08	0.15
3.Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	It was no more likely	
4.% staff experiencing harassment, bullying from relatives or public in last 12 months	26%	22%
5.% staff experiencing harassment, bullying or abuse from managers in last 12 months	15%	11%
6.% staff experiencing harassment, bullying or abuse from colleagues in last 12 months	26%	16%
7.Last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	44%	46%
8.%believing the trust provides equal opportunities for career progression or promotion	76%	87%
9.%felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	34%	26%
10.%satisfied with the extent to which their organisation values their work	37%	47%
11.Staff engagement score	6.7	7.2
12.Adequate adjustments to enable them to carry out their work	79%	N/A

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Maternity Governance Safety Report (1 October – 31 December 2019).			Meeting date: 5th February 2020
Report appendix	None		
Report sponsor	Chief Nurse		
Report author	Head of Midwifery and Gynaecology Clinical Governance Co-ordinator Midwifery Matron Audit Midwife		
Report provenance	The content of this report is a summary of the safety improvement activities implemented by the Maternity Governance Group within the Trust to meet the national priority to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025. This is informed by the Safety workstream of the Devon Local Maternity System (LMS).		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to inform the membership of the Trust Board of the work being undertaken by the Maternity Governance Group. An expectation of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme is that a quarterly report will be presented to the Trust Board. The Trust Board is asked to receive and note the report and the programme of work described.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to note the contents of the report and to support the process of review of the reports on a quarterly basis.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership	X	**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework		**Risk score**	
Risk Register	X	**Risk score**	15

External standards affected by this report and associated risks	

Care Quality Commission	**X**	**Terms of Authorisation**	
NHS Improvement	**X**	**Legislation**	
NHS England	**X**	**National policy/guidance**	**X**

Articulate any risks and implications arising from this report.

Report title: Maternity Governance Safety Report		Meeting date: 5th February 2020
Report sponsor	Chief Nurse	
Report author	Head of Midwifery and Gynaecology Clinical Governance Co-ordinator Midwifery Matron Audit Midwife	

1.0 Introduction

Torbay and South Devon Foundation Trust have various initiatives to improve the safety, care and experience of families using maternity services. As part of this governance approach maternity services, along with Neonatal and Paediatric services have robust processes in place to review and report mortality and morbidity.

The implementation of the third year of the Clinical Negligence Scheme for Trusts (CNST) supports the delivery of safer maternity care. The maternity incentive scheme applies to all trusts that deliver maternity services and are members of CNST. The scheme incentivises the implementation and evidencing of 10 key safety actions. For year 3, as with Years 1 & 2, the Board are required to have oversight of the actions and sign off that these have been implemented by the final submission date of the 17 September 2020.

Trusts that can demonstrate that they have achieved all of the ten safety actions will be eligible for a rebate on their maternity CNST contributions and will also receive a share of any unallocated funds.

In order for the Board to be sighted on progress and achievements, the maternity service provide a quarterly report to the Board. In addition, the maternity safety champions meet bi-monthly with the Executive Board Safety Champion, the Chief Nurse. This quarterly report will look back at the period 1 October 2019 – 31 December 2019.

2.0 Review and monitoring of safety within maternity services?

2.1 Safety Improvement

The maternity and neonatal services attended the launch meeting of the Maternal and Neonatal Health Safety Collaborative (MatNeo) on 25 March 2019. The team, which includes representatives from maternity and neonates have been part of Wave Three of the collaborative. They have received QI methodology training and have implemented safety changes that span the services. The project is called ‘Keeping Babies Warm’ and its aim is to improve the detection and management of neonatal hypothermia. This is due to complete in March 2020.

In addition as part of the MatNeo wave 3 activities, the service has completed a SCORE culture survey. The service had already completed a survey in 2018. This has provided us with rich data on the culture within our service and has demonstrated that the improvement activities that were undertaken following the first survey had made a difference. An example included a focus on ensuring staff took their breaks, with a resulting 10% improvement in the burnout climate domain section of the survey. The team are currently developing an action plan for further improvement activities using the findings of the second survey.

The South West Allied Health Science Network (AHSN) have held a series of Maternity and Neonatal Health Safety Collaborative Local Learning System (LLS) events. Representatives from both maternity and neonatal services have attended. This has been an excellent forum to share learning across maternity and neonatal service providers in the south West. Within TSD, we are extremely fortunate that our System Medical Director, Joanne Watson, is the clinical lead for AHSN and also participates in these events.

2.2 Mortality and Morbidity

2.2.1 Perinatal Mortality Review Tool (PMRT)

The PMRT tool has now become embedded in practice following its introduction in 2018. It has been used at the local multi-disciplinary case reviews to inform the reviews, and within the prescribed timescale. The standard is that there should be at least two obstetricians and two midwives present for each review. Locally we have been able to achieve this. We often have additional midwives and medical staff participate as we undertake the reviews as part of the junior medical staff teaching sessions.

During the reporting period, we had one 24 week stillbirth and one late fetal loss (Babies born between 22+0 and 23+6 showing no signs of life irrespective of when the death occurred). Duty of candour was undertaken and families were asked if they had any questions that they would like be included within the review of the care provided. There were no themes from these two cases other than they were both severely preterm.

2.2.2 Healthcare Safety Investigation Branch (HSIB)

HSIB continue to investigate births and Maternal deaths that meet their referral criteria. Between October and December 2019 we had one baby that met the criteria. This baby was delivered at hospital very soon after arrival by ambulance. Following born who met the criteria for active cooling following delivery in hospital. The woman agreed for HSIB to investigate her care and management.

During this time period we received a draft report for a case from February 2019. This report was sent to all staff who had been interviewed by HSIB as part of the investigation. It was been finalised at the end of December 2019 and shared with staff.

An action plan is in the process of being developed that considers the HSIB recommendations.

2.2.5 NHS Resolution

During the reporting period, the Trust has passed one case onto the Trust legal team to report to the NHS resolution team. This is the same case that met the referral criteria to HSIB. All cases were reported to the early notification scheme within the required timescales

We have received feedback in relation to four cases. Three cases were assessed as not substandard care. One case has been referred to the Trust solicitors for further review. The maternity service had already undertaken its own review of the case and identified the same issues: potential delay between rupture of membranes and administration of Propess to induce labour, and delay in performing caesarean section once request made. The learning from these was shared with staff at the time of the review.

2.2.6 *Saving Babies' Lives Care Bundle*

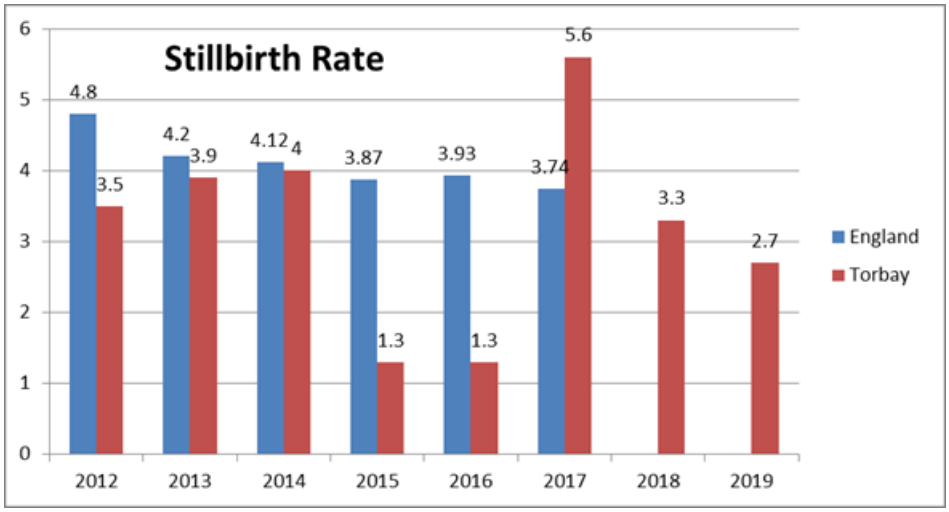
On the 15 March 2019, the maternity team attended the launch of Saving Babies Lives Care Bundle Version 2 (SBLCB v2). This builds on the existing bundle, but adds a fifth element for implementation. This relates to preventing preterm labour. There is an expectation that all elements will be implemented by 31 March 2020. The maternity team have undertaken a benchmarking exercise and have developed an action plan.

It will not be possible to implement all aspects of the bundle without investment. The resources required will be additional Consultant Obstetric PAs, 0.4wte Band 7 Midwife and additional sonography capacity. Business cases have been developed and are due for submission.

Regular flash reports, completion of quarterly surveys and meetings are in place to support implementation of the action plan with the aim for full compliance by 31st March 2020. This is monitored through our Maternity Governance meeting. Our current survey findings that have been reported to NHSE.

One of the aims of SBLCB v1 and v2 is to reduce the number of still birth. Our 2019 annual data is now available and has shown that the still birth rate has reduced at TSD for the 2nd year in a row. This is shown in Table 1 (Note: national comparative data is not yet available for 2018 & 2019)

Table 1: Annual Stillbirth Rate



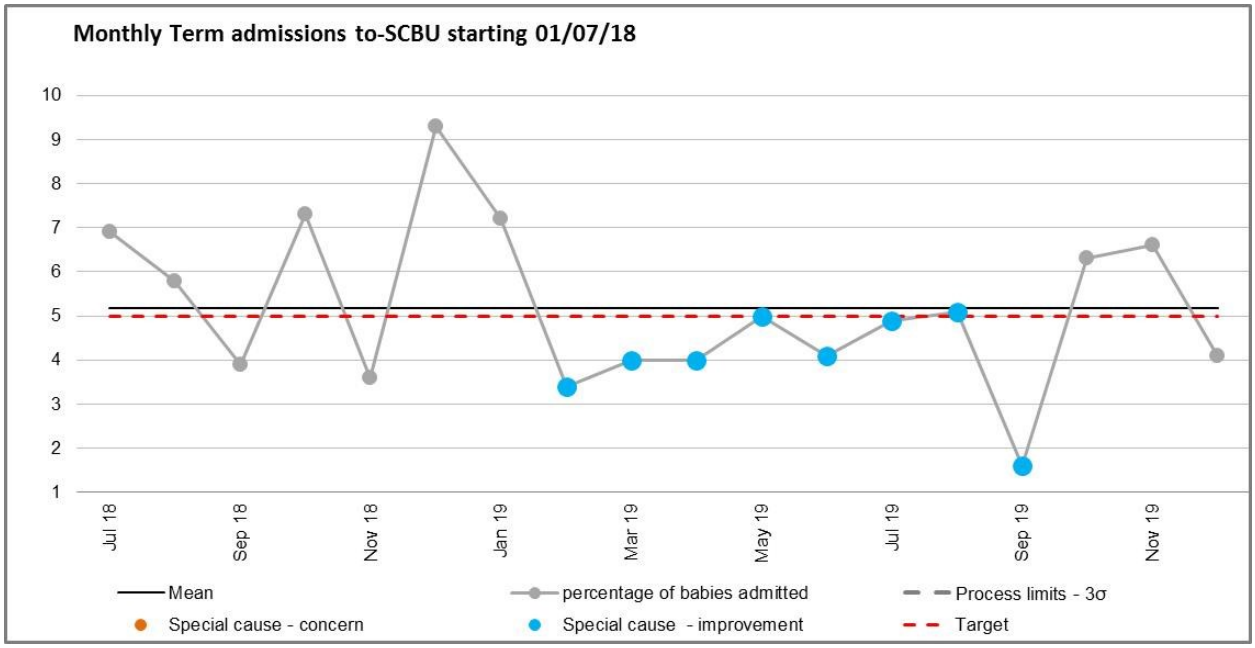
2.2.7 *Avoiding Term Admissions into Neonatal Units – ATAIN*

There is ongoing collaborative work between the Maternity Service and Child Health in relation to ATAIN. The trust continues to report data to the ATAIN programme on a quarterly basis and has an ongoing action plan. ATAIN is a CNST key safety action, with progress against the action plan being shared with the Board Level Champion. For this reporting period, 5.2% of term births were admitted to the Special Care Baby Unit. This is an increase from the last reporting period and is slightly above the target of 5% or less. This may have been affected by the fact that October and November were exceptionally busy months within the service and there were capacity issues within the midwifery staffing levels. However, there were a significantly higher number of babies cared for under the Transitional Care Model on the postnatal ward in October and November and without this facility, the term admissions to Special Care would have been notably higher. For the year to date, there have been 4.9% of term births admitted to Special Care, which remains within the target figure.

See table 2 for monthly term admission to SCBU rate.

As a service we are at the limits of what we can achieve in relation to this important safety and quality action. This is due to space and capacity issues within the clinical area. The estates strategy for the Women's Health Unit, which has been approved but is awaiting allocation of capital funding, includes provision of bespoke Transitional Care Facilities. This would enable us to continue our improvement journey to support the on-going care of babies with additional needs, but not requiring SCBU and ensuring mothers and babies are not separated.

Table 2 for Monthly Term Admission to SCBU Rate



2.2.8 Maternity Safety Champions

There is the requirement for the Trust to have a two designated Safety Champions (a midwife and an obstetrician) within the Maternity Service who liaise regularly with the Board Level Safety Champion. Within the Maternity Service the midwifery role was previously undertaken by the Clinical Governance Coordinator for Obstetrics and Gynaecology but has recently been taken over by the Matron for Maternity and Gynaecology. The role of the Board Level Safety Champion has also changed from the Medical Director to the Chief Nurse. Bi-monthly meetings for the year 2020 have been arranged between the Maternity Safety Champions and the Board Level Safety Champion.

The new Maternity Safety Champion will be undertaking work to meet the CNST requirements (see Appendix 2) which include developing a pathway which describes how the Board Safety Champions and frontline staff within the maternity, obstetric and neonatal services share safety information from the floor to the Board and through Local Maternity System (LMS) and Local Learning Systems (LLS). They will also support the Board Level Safety Champion with monthly feedback sessions to allow maternity and neonatal staff the opportunity to raise safety concerns. An action plan will be produced and overseen by the Board Level Safety Champion describing how the Maternity Service will achieve a minimum 51% of women receiving a continuity of carer pathway during their pregnancy and labour by March 2021. The Maternity Safety Champions will assist the Board Level Safety Champion to support capacity and capability for staff

involved in maternity and neonatal quality and safety improvement programmes, the Local Learning Systems, the MatNeo Safety Improvement Programme and national Clinical Improvement Leaders Group.

3.0 CNST: 10 Key Safety Actions

NHSR published the expected safety actions for year 3 of the maternity incentive scheme on 20 December 2019. Achievement of all 10 of the safety actions will result in a rebate of part of the CNST contribution to the Trust. There have been significant changes to the standards. The maternity service team have held a meeting on 13 January 2020 to fully review the document and develop an action plan to support achievement of the safety standards. Leads have been allocated for each element.

A benchmarking exercise has been completed to review the service's current position. This was shared at the January 2020 Torquay ISU Governance meeting.

Having reviewed the document, there is a significant amount of work to be completed to evidence achievement of the safety actions. This will require Board sign-off by Thursday 17 September 2020. However due to the dates that the Board is being held, it has been requested that the team submit the final report to the Board for the July Board date. The team already have a number of processes in place that will aid the evidence collation; however, there will be a requirement for additional resource to be able to achieve some of the standards. Business cases have been and are being developed to support achievement of the safety actions.

4.0 Conclusion

The drive to improve safety in maternity services is a key part of the NHS Long Term Plan. This report describes a significant amount of improvement activity taking place and the systems that are in place to provide assurance. The action plans and their monitoring aims to reduce avoidable harm in maternity services and sets clear actions to meet the key drivers of the national safety agenda.

The 10 Key Safety Actions require resource to ensure implementation. The evidence requirements have significantly increased for year three; however the team remain committed to achieving the standards in order to continue on their safety journey.

5.0 Recommendations

The Trust Board is asked to monitor the safety actions required by the CNST maternity incentive scheme, acting on new recommendations or actions as they arise or are completed.

The Trust Board is asked to note that they are required to provide sign off that they have seen evidence of compliance with all 10 Key Safety Steps and the requirement to submit a declaration by noon on 17 September 2020.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Midwifery Staffing Oversight Report			**Meeting date:** 5 February 2020
Report appendix	Nil		
Report sponsor	Chief Nurse		
Report author	Head of Midwifery and Gynaecology		
Report provenance	The content of this report is a summary of Midwifery Staffing within the maternity service to ensure safe staffing levels as recommended by NICE. This is monitored by the Maternity Clinical Governance Group.		
Purpose of the report and key issues for consideration/decision	There are clear standards for effective midwifery workforce planning. NICE guidance, NG4 (2015) recommends that the midwifery establishment is reviewed at Board Level at least every 6 months. This has been achieved through quarterly meetings between the Chief Nurse, System Director of Nursing and the Head of Midwifery and through inclusion in the Chief Nurse's 6 monthly Midwifery staffing report that are taken to the Board. The maternity service produces a monthly report summarising the staffing establishment, sickness rates, red flag issues, escalation and actions. A copy of this is sent to the Chief Nurse. The Clinical Negligence Scheme for Trusts (CNST) maternity incentive, Year 3, set out clear expectations in relation to demonstrating an effective system of midwifery workforce planning. The required standards are as follows: a) A systematic, evidence based process to calculate midwifery staffing establishment is complete b) The midwifery co-ordinator in charge of labour ward must have supernumerary status (defined as having no caseload of their own during a shift) to ensure there is an oversight of all birth activity within the service c) All women in active labour receive one-to-one care d) Submit a bi-annual midwifery staffing oversight report that covers staffing / safety issues to the Board. This report covers the time period July 2019 to December 2019 and details compliance with the above standards.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐

<table>
<tr><td>Recommendation</td><td>For the maternity service to continue to monitor midwifery staffing on a monthly basis and ensure meeting the recommendation set out by NHS Resolution

That the Board receives and notes the report.</td></tr>
<tr><td colspan="2">Summary of key elements</td></tr>
<tr><td>Strategic objectives supported by this report</td><td>
<table>
<tr><td>Safe, quality care and best experience</td><td>√</td><td>Valuing our workforce</td><td></td></tr>
<tr><td colspan="2">Improved wellbeing through partnership</td><td></td><td>Well-led</td><td>√</td></tr>
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<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
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<tr><td>Board Assurance Framework</td><td></td><td>Risk score</td><td></td></tr>
<tr><td>Risk Register</td><td></td><td>Risk score</td><td></td></tr>
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<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td>√</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>√</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>√</td><td>National policy/guidance</td><td>√</td></tr>
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Midwifery Staffing Oversight Report		Date: 5 February 2020
Report sponsor	Chief Nurse	
Report author	Head of Midwifery and Gynaecology	

1.0 Introduction

There are clear standards for effective midwifery workforce planning. NICE guidance, NG4 (2015) recommends that the midwifery establishment is reviewed at Board Level at least every 6 months. This has been achieved through quarterly meetings between the Chief Nurse, System Director of Nursing and the Head of Midwifery and through inclusion in the Chief Nurse's 6 monthly Midwifery staffing report that are taken to the Board.

The maternity service produces a monthly report summarising the staffing establishment, sickness rates, red flag issues, escalation and actions. A copy of this is sent to the Chief Nurse.

The Clinical Negligence Scheme for Trusts (CNST) maternity incentive, Year 3, set out clear expectations in relation to demonstrating an effective system of midwifery workforce planning. The required standards are as follows:

a) A systematic, evidence based process to calculate midwifery staffing establishment is complete
b) The midwifery co-ordinator in charge of labour ward must have supernumerary status (defined as having no caseload of their own during a shift) to ensure there is an oversight of all birth activity within the service
c) All women in active labour receive one-to-one care
d) Submit a bi-annual midwifery staffing oversight report that covers staffing / safety issues to the Board.

This report covers the time period July 2019 to December 2019 and details compliance with the above standards.

2.0 Midwifery Staffing Establishment (a)

NICE, Safe Midwifery Staffing for Maternity Settings (2015) recommend the use of the Birthrate Plus ® Workforce Planning Methodology Tool, along with the Birthrate Plus ® Intrapartum Tool.

During the latter part of 2017, the maternity service underwent a Birthrate Plus ® assessment. The initial findings were that there were no significant recommendations regarding variations to the establishment. This outcome was reported to the Board.

In June 2018 the final report received demonstrated that the existing midwifery establishment was set at the right level for the activity at that time. It was noted that the midwifery establishment was 1.18wte over, whilst the support worker role was 1.65wte under established. However overall there was a -0.47 variance. During August 2018, there had been no significant changes to the midwifery activity and

therefore the service took the opportunity to undertake further skill mixing and 1wte midwifery post was converted to a 1.4wte support worker role. This meant that the establishment now matched the recommendations set out within the Birthrate Plus ® report.

From April 2019, the maternity service began to use the Birthrate Plus ® Intrapartum Tool. This has enabled electronic monitoring of the acuity of women in our care, monitors supernumerary status of the delivery suite co-ordinator and captures red flag incidents, including one-to-one care.

The senior midwifery team review the midwifery establishment on a monthly basis. This enables the team to identify any potential issues arising in the future and enables them to put contingencies into place.

During the 6 month period covered within this report, we have seen a midwifery vacancy range of 0.6wte – 3.7wte (see Table 1). The service is usually recruited to establishment, however this year we have seen a bulge in vacancies due to planned retirements. All vacancies have been recruited to throughout the time period; however the length of time taken for the recruitment process has meant that there has been delays in new midwives starting their roles. We have also supported staff to move to different areas of the maternity service, which again results in a vacancy that then needs to be recruited to. Due to the locally agreed minimal staffing requirements, we have backfilled these vacancies utilising bank and substantive staff doing additional hours.

	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19
Establishment	87.3	87.3	87.3	87.3	87.3	87.3
In post during month	85.7	86.7	84.2	82.3	83.7	83.6
Maternity leave	1.8	1.8	3.2	4	4	4
Maternity leave cover	2.0	2.0	2.0	3.6	3.6	3.6

Table 1: Planned versus actual midwifery staffing levels

Another indicator of appropriate staffing levels is the use of the midwife to birth ratio. This is calculated by dividing the total number of births by the whole-time equivalent number of midwives. This is a crude calculation as only considers births and not all of the other activity that is required. The current national recommendation is a ratio of 1:28 midwives; however this ratio is likely to be reduced due to the recognition of the additional requirements for midwifery staff. It can be measured in two ways, firstly the total number of midwives excluding the Head of Midwifery (HOM) over the year's births. When calculated in this manner, the Midwife to Birth ratio at Torbay and South Devon (TSD) is **1:28.**

However, on a monthly basis, TSD are required to submit the Midwife to Birth ratio to NHSE South West to form part of the South West Maternity Network Dashboard. A standardised calculation is undertaken, which uses the current month's births and the whole-time midwifery establishment, excluding the HOM, midwifery matrons and

specialist midwives. Table 2 details the Midwife to Birth Ratio that has been reported between July and December 2019.

Time period	Midwife:Birth Ratio
Jul 2019	1:31
Aug 2019	1:27
Sep 2019	1:27
Oct 2019	1:29
Nov 2019	1:25
Dec 2019	1:23

Table 2: Midwife to Birth ratio (exc. HOM, matrons and specialist roles)

The overall birthrate has dropped slightly, which is why the figures in table 2 reflect a lower midwife to birth ratio as it is calculated using the number of births for that month. However the complexity and acuity of women, both medically and socially, is increasing. This is evidenced by the increase rates of medical interventions, such as induction of labour and caesarean section, and a subsequent rise in the length of stay for women.

The number of midwives who are not included within the clinical numbers, such as specialist midwives and midwifery managers equates to 10% of the midwifery workforce. This is in line with the recommendations of Birthrate Plus ®

In addition to the above, there have been a number of National trajectories that have been set by NHSE in relation to the provision of maternity care. This has resulted in the requirement to redesign our midwifery service to meet the requirement that the majority of women receive continuity of carer from a small team of midwives.

Given these changes, and following discussion with the Chief Nurse, we anticipate repeating the Birthrate Plus ® Assessment be in Autumn 2020 once the new model is established to ensure that the staffing establishments are set to meet activity levels.

3.0 Labour Ward (Delivery Suite) Co-ordinator Supernumerary Status (b)

Our maternity staffing document sets out that the delivery suite co-ordinator is a supernumerary role. Until the implementation of Birthrate Plus ® Intrapartum Acuity Tool it was not possible to capture data in relation to the supernumerary status. From the 1 April 2019 the delivery suite co-ordinators have been recording any instances where they have been unable to have supernumerary status.

2019	Instances where delivery suite co-ordinator is not supernumerary
July	11
August	4
September	8
October	11
November	5
December	9

Table 3: Summary of Delivery Suite Co-ordinator Supernumerary Status

During the six month period there were 48 instances out of 1104 recording points. This equates to 4%, which is an increase from the preceding 6 months. For all instances where the co-ordinator was not in a supernumerary capacity, this had not been the intention for that shift. Our midwifery establishment is set to enable the co-ordinator to be supernumerary and this is supported by our maternity staffing document.

For each shift, the co-ordinator will assess the workload and allocate staff accordingly. The service has a clear escalation plan and the co-ordinator has a number of actions that they can take at times of high acuity or if there is unexpected staff absence. Taking over the care of a woman on delivery suite is one of the last actions that the co-ordinator will do, however they will weigh up the balance of risk in taking this action. Should they deem this necessary, they will care for women who have low acuity, such as a postnatal woman and have minimal care requirements, to release a midwife to care for a woman who has higher acuity. This enables them to maintain their helicopter view of the maternity service. The co-ordinator will return to supernumerary status at her earliest opportunity.

The maternity service has an escalation process to help mitigate against this risk, which includes an additional midwife available on-call to support at times of high acuity.

The midwifery matrons review the acuity tool on a weekly basis and provide the Head of Midwifery and Gynaecology with a report outlining any instances where the co-ordinator is not supernumerary. All shifts are planned with the co-ordinator in a supernumerary capacity, therefore we have developed an action plan to ensure that the role of the co-ordinator is protected during each shift. We would aim to have 100% compliance for the next 6 monthly report to the Board.

- Midwifery Matron with responsibility for delivery suite (MM), or deputy, to meet with co-ordinator within one week (unless occurs immediately before annual leave) to review the circumstances for the non-supernumerary period
- MM to explore if alternative course of action could have been taken
- MM to identify if any actions are required as a result of episode
- MM to clarify with co-ordinators what is meant by supernumerary status to ensure consistent reporting

4.0 Women receiving one-to-one care in labour (c)

The maternity service previously captured the number of women receiving one-to-one care in labour at four set points throughout a 24 hour period, every day. Since

January 2019, we have changed how we monitored this KPI. Rather than points in time, it is now completed for each woman and recorded on the STORK maternity system. This has improved data accuracy and as such we have noted a small dip in performance. This data is monitored and is one of the maternity specific questions on the QUESTT tool. The aim is to achieve 100%.

Time period	%
Jul 2019	99
Aug 2019	96
Sep 2019	96
Oct 2019	95
Nov 2019	94
Dec 2019	96

Table 4: Percentage of women receiving one-to-one care in labour.

The maternity service works extremely hard to ensure this standard is met as can be seen in Table 4. Over the six month time period, this equates to approximately 8 women per month not receiving one-to-one care in labour. However this raw data does not tell us for how long that woman did not receive one-to-one care.

Anecdotally midwives report that this is usually for short periods of time, where they may be required to provide care for another woman whilst additional midwifery staffing is sought, such as use of the escalation on-call midwife. As a senior team we are assured that one-to-one care is prioritised and action is taken to remedy the situation as soon as practically possible.

5.0 Bi-annual report (d)

The senior midwifery leadership team completes a monthly staffing report, which is shared with all maternity staff team members. The purpose is to ensure that staffing levels are closely monitored by the leadership team. It provides transparency for the team and assurance that staffing is being monitored and actions taken.

The monthly staffing report contains information on sickness, minimum staffing levels, use of escalation staff, supernumerary status for delivery suite co-ordinator, one-to-one care in labour, red flags and the midwife to birth ratio. Feedback from staff is that they find the report useful and easy to read.

The monthly report is also shared with the Chief Nurse, Director of Nursing and the Torquay Integrated Service Unit Leadership Team. These reports are used to inform the content of the biannual report.

This is the third specific maternity report. The biannual report is completed six monthly, with the next report being due in July 2020.

6.0 Red flags

NICE guidance identifies a number of events that can be viewed as red flags. These are signs that there may not be enough midwives available. They identified 9 events, whilst locally we have added a further flag (denoted with an *).

- Activities that need to be done on time are delayed or cancelled.
- After giving birth, a woman has to wait for 60 minutes or more before she is washed or given stitches, if she needs them.
- A woman does not get the medicines she needs when she's been admitted to a hospital or a midwifery-led maternity unit.
- A woman has to wait 30 minutes or more to get pain relief when she's been admitted to a hospital maternity unit or a midwifery-led maternity unit.
- A woman who is in labour or who has a problem needing midwife care has to wait 30 minutes or more for assessment after the midwife has been alerted.
- A woman is not given a full examination when she reports she is in labour.
- There is a delay of 2 hours or more between coming in for an induction and the induction being started.
- Delays in spotting and acting on signs that the woman may have a serious health problem
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman in established labour
- Unable to provide an out of hospital birth when requested*

From April 2019, red flag events and action taken in response to these were captured using the Birthrate Plus ® Acuity Tool.

Red flag	Descriptor	Incidence					
		Jul	Aug	Sep	Oct	Nov	Dec
RF1	Delayed or cancelled time critical activity	0	1	1	1	0	0
RF2	Missed or delayed care	3	3	2	1	3	2
RF3	Missed medication	0	0	0	0	0	0
RF4	Delay in providing pain relief	0	0	0	0	0	0
RF5	Delay between presentation and assessment	0	0	0	0	0	0
RF6	Full clinical examination not carried out when presentation in labour	0	0	0	0	0	0
RF7	Delay of ≥2 hours between admission for induction of labour and beginning of process	2	1	0	3	1	0
RF8	Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0
RF9	121 care in labour	2	0	3	2	0	0
RF10	Unable to facilitate out of hospital birth	3	5	4	3	0	0

Table 5: Midwifery Red Flag Events

The use of the acuity tool now enables us to track when red flags occur. Chart 1 provides an example of acuity data. From our analysis of the system, red flags generally occur at times of high acuity the number of red flag events increase. The matrons review any red flag events with the co-ordinator, using the same process as the supernumerary status.

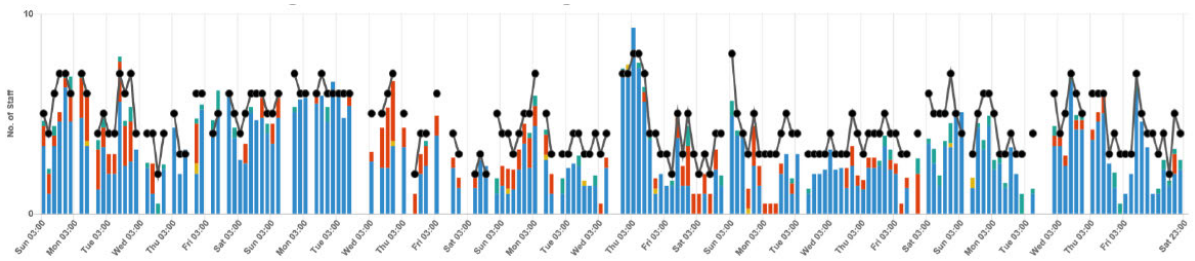

Chart 1: Staffing v Workload Example

All red flag instances were due to a conscious decision to trigger the red flag to ensure safety across the whole service was maintained. None of the instances were due to omissions or lapses in care. The most common reason for a red flag is a delay in continuing an induction of labour process. This is mainly due to the significant rise in the rate of induction of labour due to a change in national guidance. This has had a significant impact on capacity and flow within the maternity unit. Anecdotally Maternity Units from across the country are reporting similar issues. The clinical team are currently exploring how this risk can be reduced.

The guidance on red flags is very clear, in that a red flag should only be raised if the incident is due to unavailability of midwifery staff. It has become evident over the last two months that some red flags have been noted, but when explored further, the event occurred due to lack of bed capacity and not midwifery staffing levels. This was discussed with the staff completing the data entry and it can therefore be seen during November and December that the number of red flags has reduced.

7.0 Sickness

During the six month reporting period there was a peak in midwifery absence due to sickness in July. This has slowly reduced over the time period, but has seen a slight increase toward the latter part of the year due to coughs, colds and respiratory symptoms.

The leadership team work proactively with the Human Resources department and staff members to support them to return to work as soon as they are fit to do so. This is monitored with our monthly staffing report, which can identify specific areas within the maternity service that may require additional support. This includes where midwifery staffing levels do not meet the locally agreed minimum staffing levels. This is also shared with staff.

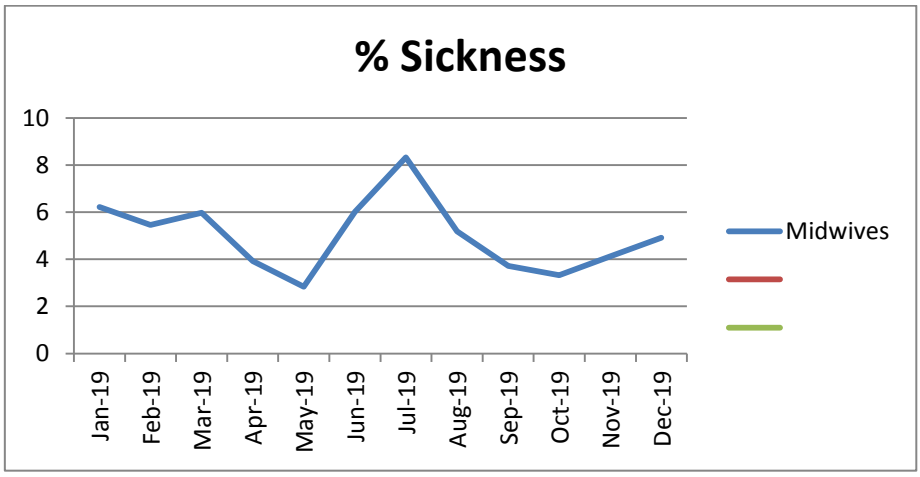

Table 6: Midwifery Sickness Percentage

8.0 Escalation

The maternity service has a clear escalation process for when demand exceeds capacity. This includes the use of an escalation on-call midwife outside of core working hours to support high acuity. This is monitored through the monthly staffing reports.

Time period	No. of Times Escalation Midwife Used
Jul 2019	3
Aug 2019	1
Sep 2019	4
Oct 2019	6
Nov 2019	1
Dec 2019	2

Table 7: Summary of escalation midwife usage

9.0 Conclusion

The midwifery staffing establishment is set at the right level, enabling effective deployment of staff across the service. This is monitored closely by the leadership team, who have instigated a monthly reporting system to enable this monitoring and improve assurance.

We have a robust escalation process in place, which was utilised as needed. The introduction of the Acuity Tool has enabled closer monitoring of KPIs and review of any actions required. It has also enabled the data to be shared in a visual way with staff members.

10.0 Recommendations

- For the maternity service to continue to monitor midwifery staffing on a monthly basis and ensure it is meeting the recommendation set out by NHS Resolution

- To repeat the Birthrate Plus Establishment Review is repeated in Autumn 2020

- That the Board receives and notes the report.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Mortality Surveillance Score Card			Meeting date: 5th February 2020
Report appendix	N/A		
Report sponsor	Medical Director		
Report author	Patient & Experience Lead		
Report provenance	Data is taken from Hospital Episode Statistics and Dr Foster Reviewed by Executive Directors on 28th January 2020.		
Purpose of the report and key issues for consideration/decision	To provide information on the mortality of patients who have used the inpatient services of the Trust and assurance on any associated risks and actions.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	To review the information included in this report		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	Y	**Valuing our workforce**	
Improved wellbeing through partnership		**Well-led**	Y

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework		**Risk score**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission		**Terms of Authorisation**	
NHS Improvement		**Legislation**	**Y**
NHS England		**National policy/guidance**	

Report title: Mortality Surveillance Score Card		Meeting date: 5th February 2020
Report sponsor	Medical Director	
Report author	Patient and Experience Lead	

1. Introduction & Data Source

The indicators for this score card have been collated from a variety of data sources using defined methodology. The report is designed to give a top level view of our bed based mortality over time. The report also includes mortality cases reviewed via the Trusts Morbidity and Mortality form based on the Royal College of Physicians Structured Judgement Frame Work (SJF) looking at any lapses in care as well as good practice. Data sourced includes data from the Trust, Department of Health (DH) and Dr Foster. The data in the appendices has, in the main, been displayed as run charts. The report is generated for the Trust Board, Quality Improvement Group, and Mortality Surveillance Group as well as local SDU governance groups.

The run charts used are designed to look for *trends* and *shifts* in the data.

Trends: If 5 or more consecutive data points are increasing or 5 or more consecutive points decrease, this is defined as a trend. If a trend is detected it indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of process starting to err.

Shifts: If 6 or more consecutive data points are all above or all below the median this indicates a non-random pattern in the data which may be a signal of improvement or of a process starting to err.

Table 1: Torbay & South Devon NHS Foundation Trust Data Sources

Safety Indicator		Data Source	Target	RAG
Appendix 1 • Hospital Standardised Mortality Rate (HSMR) • Summary Hospital Mortality Index (SHMI)	Mortality	Dr Foster 2016/17 benchmark Month DH SHMI data	Below the 100 line with an aim for a yearly HSMR ≤90	97.2
Appendix 2 • Unadjusted Mortality rate		Trust Data	Yearly Average ≤3%	3.06%
Appendix 3 • Dr Foster Alerts		Dr Foster		
Appendix 4 • Dr Foster Patient Safety Dashboard		Dr Foster	All 15 safety indicators positive	3 indicators better than average
Appendix 5 • Hospital Mortality		Trust Data Structured Judgement Framework M&M reviews		
Trustwide Overview				

Overview: The Hospital Standardised Mortality Rate (HSMR) is below the 100 mark for the latest data month, Septmeber 19 and within Dr Fosters expected range. The Summary Hospital Mortality Index (SHMI) remains within the accepted range for our population and has been for a prolonged period.

Work is on-going with Coding and the Information Team looking at Trustwide Palliative Care Coding, as this is decreasing and could adversely affect our HSMR. Coding is also working with the Information team on reseding records that have been reviewed.

The Trust is an active lead at the STP mortality surveillance group looking to harmonise and standardise coding and mortality factors on a STP wide setting in Devon. The STP mortality surveillance group reports to the STP Quality Surveillance Group.

The Trust has recruited 5 Medical Examiner's (ME), including a Lead ME and has submitted a business case for the Medical Examiners Office. The MEs will take up the posts in January.

Appendix 1 Hospital Mortality

This metric looks at the two main standardised mortality tools and is therefore split into:

- **1A – Dr Foster Hospital Standardised Mortality Rate (HSMR) and**
- **1B – Department of Health Summary Hospital Mortality Index (SHMI)**

1A The HSMR is based on the *Diagnosis all* Groups using the Jun 19 monthly benchmark and analysed by Relative Risk - Trend / Month

Our HSMR Measure aim is to reduce and sustain the HSMR below a rate of ≤90

A rate above 100 coupled with a ***high relative risk*** may signify a concern and needs to be investigated. This is normally indicated by a red diamond and error bars which exceeds the 100 line

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Chart 1 - HSMR by Month Oct 16 – Sept 19
Chart one (as below) shows a longitudinal monthly view of HSMR as well as highlighting the current month. The latest month's data, Sept 19, has a relative risk of **97.2** – this may change as more data is processed by Dr Foster. This data point has returned to below the 100 mark, and is within the expected range.

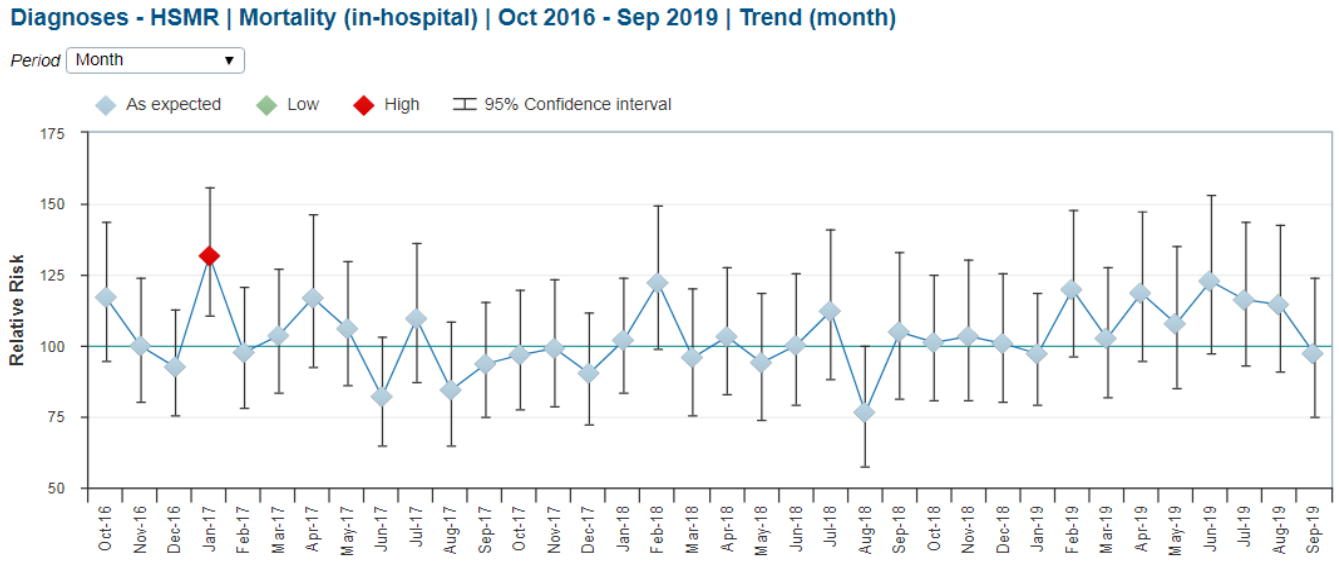


Chart 2, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12 month annual total. The monthly 12 monoth annual total remains below the 100 line.

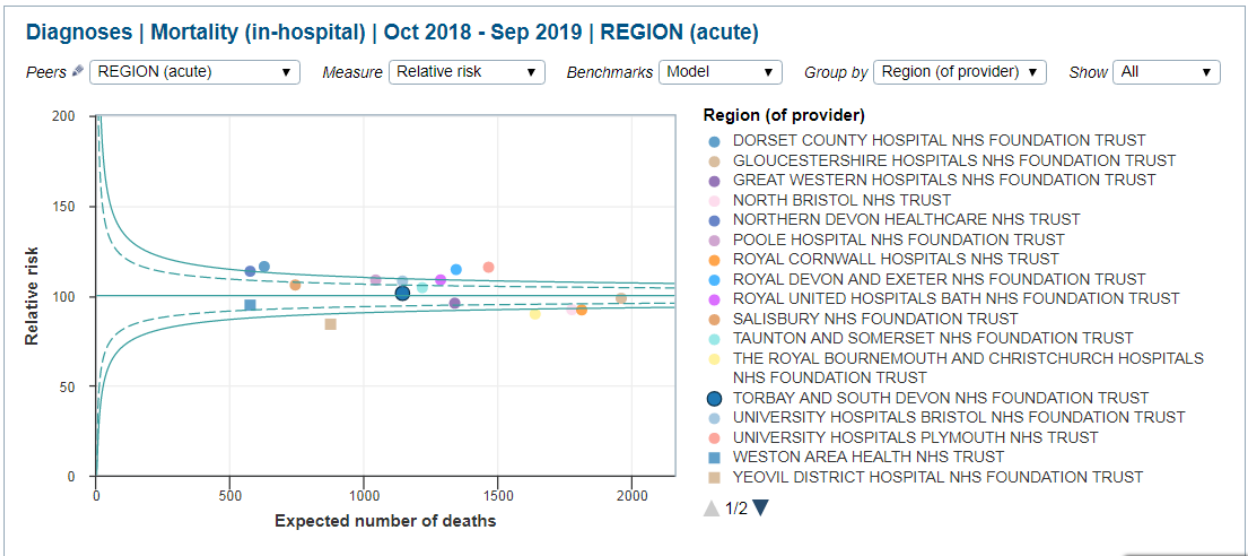
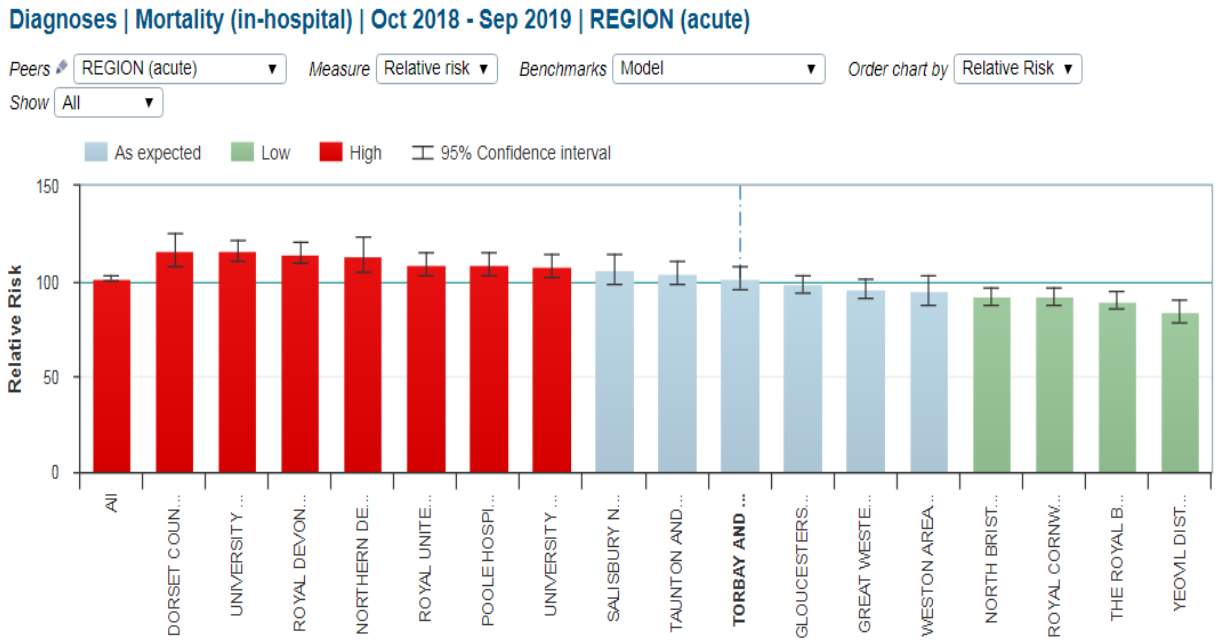


Chart 3 displays the above data as a Peer Comparison, ranked, and as a bar chart.



1B Summary Hospital Mortality Index (SHMI) Reporting Period Aug 2018 – July 2019

SHMI is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon death up to *30 days* post discharge from hospital and this is the main difference between SHMI and HSMR. The data is released on a **3 monthly basis** and is very retrospective therefore, please note *the following data is based on the Aug 2018 – July 2019 data period and is **different** to HSMR.*

Chart 4, as below, highlights SHMI by quarter period with all data points within the expected range and trending over time at our 90 relevant risk target line. The latests SHMI is **90.58**

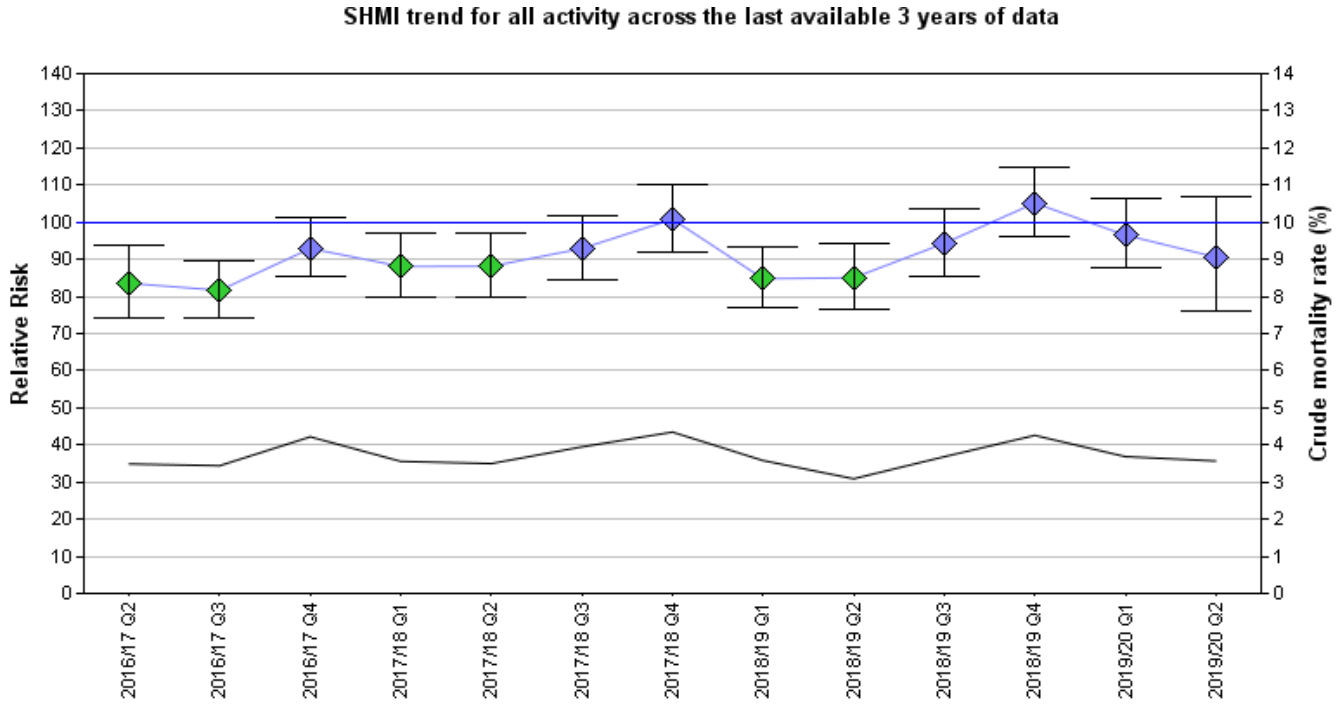
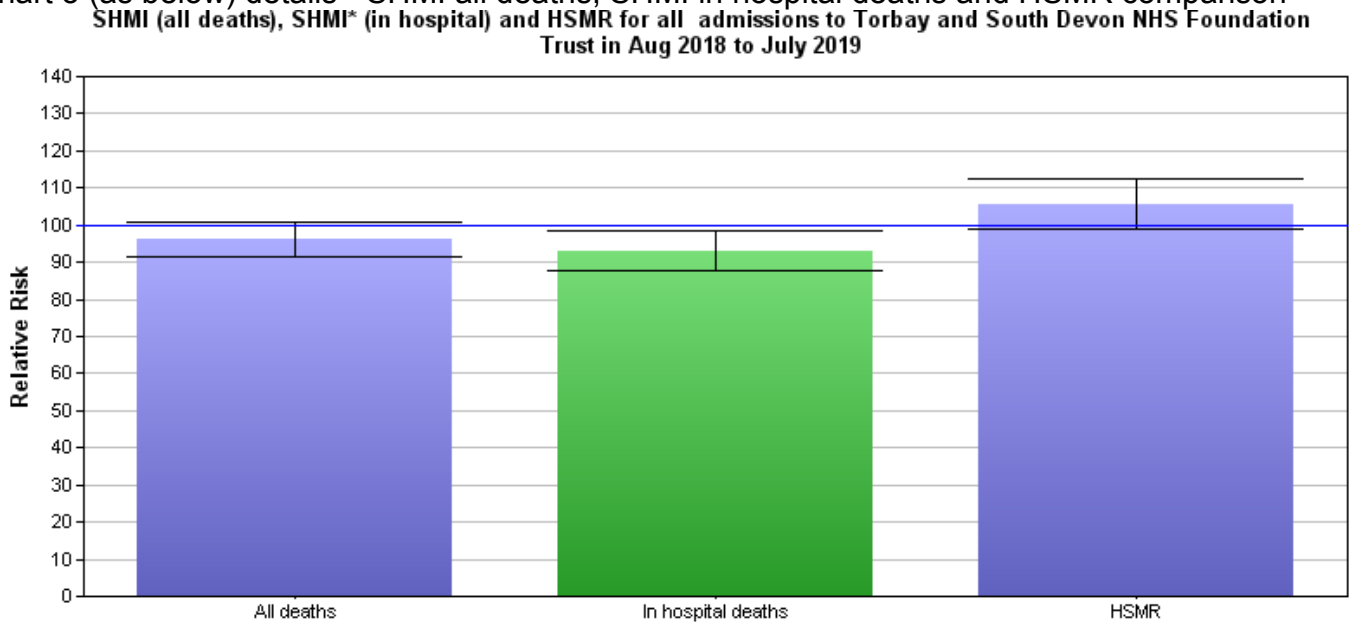


Chart 5 (as below) details - SHMI all deaths, SHMI in hospital deaths and HSMR comparison



The SHMI data within chart 5 are within expected range and show the in-hospital deaths at a very low relative risk. What this chart does highlight is the differential between HSMR and SHMI.

Chart 6, as below, expresses the 12-month rolling SHMI data by time period and is showing a SHMI below the 100 average,

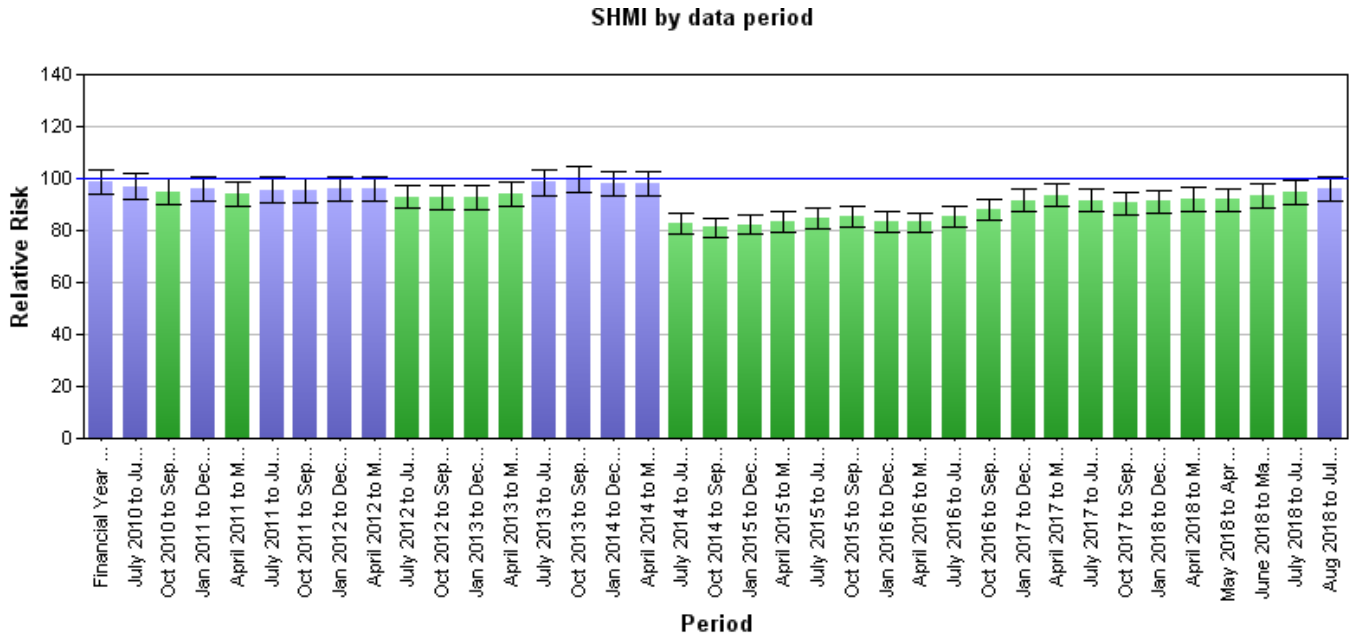
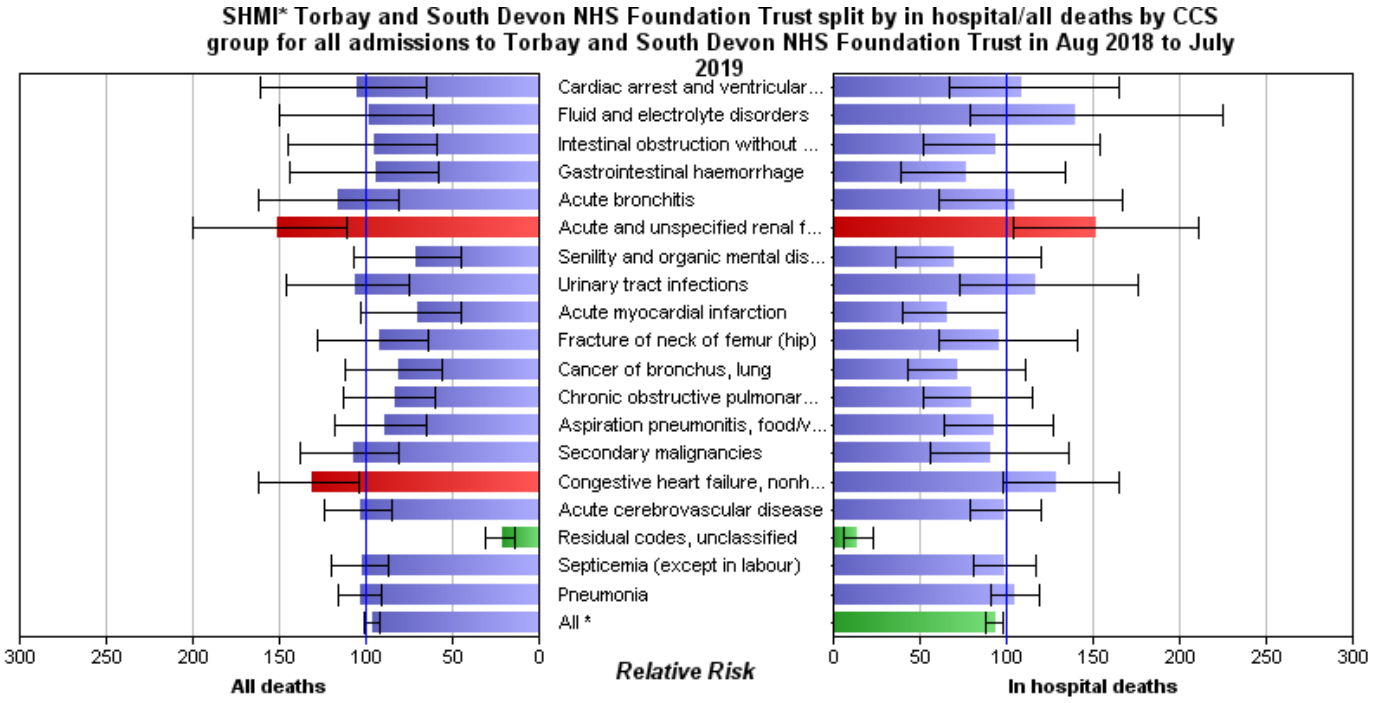


Chart 7 allows a comparison of the mortality clinical classification software (CCS) groups for in hospital and all deaths (i.e. within 30 days post discharge). All areas are within *normal range* or are performing *better than the norm* except Acute and Unspecified Renal Failure (A&URF). This will be discussed at the Mortality Surveillance group for releveance and planned action



Appendix 2

This data looks at the number of deaths in-hospitals and expresses this as an unadjusted death rate as a percentage, as well as by number and location across time

This percentage is defined as the monthly unadjusted or 'raw' mortality. It is calculated as follows:

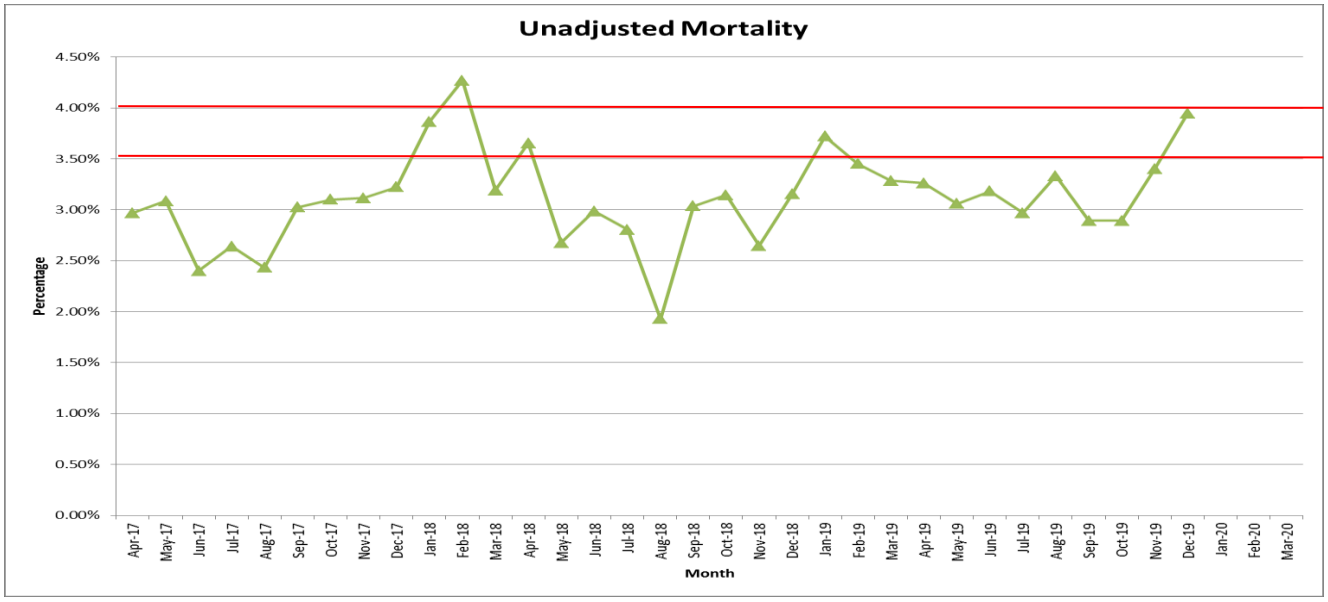
Determine the numerator: the total number of in hospital deaths (TD) for the current month (excluding stillbirths and deaths in A & E).

Determine the denominator: the current month's total number of deaths (TD) + live discharges (LD).

Calculate the actual percent monthly-unadjusted mortality by dividing (TD) by (TD + LD) and then multiply by 100.

Chart 8, as below, highlights **t**he Trusts in hospital unadjusted mortality. This has to be viewed along with the more in-depth analysis provided by HSMR and SHMI.

This chart shows an increase which occurs during the winter months (Dec – Mar). This is eveident, over the charted 3 year period. More data points will be needed to compare against the previous years data.



The bar below chart shows average age at death for each area in 2019.

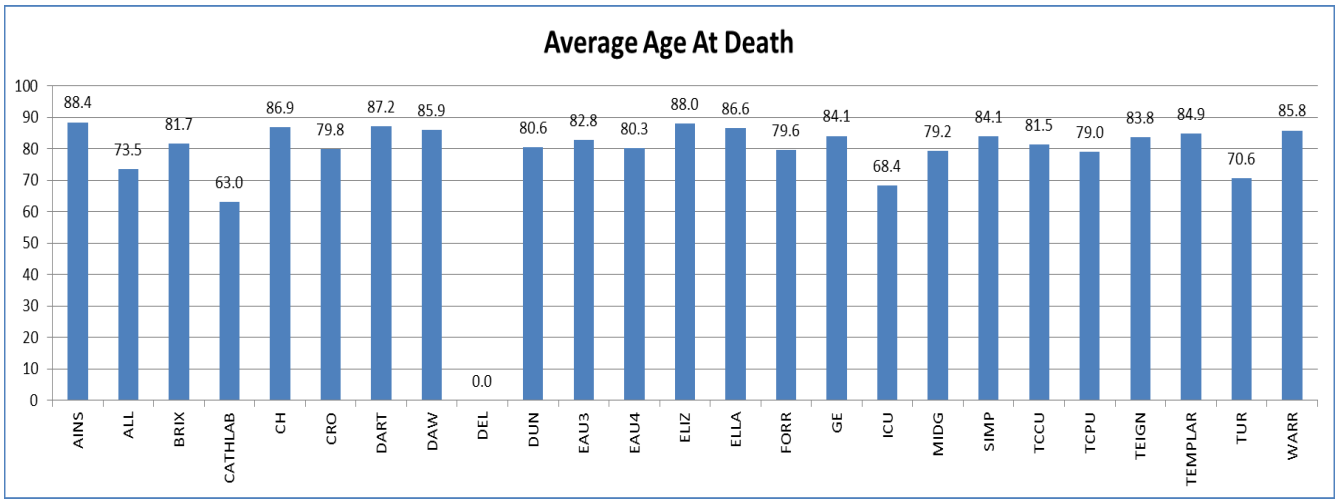


Table 1 – as below, records mortality by ward by number and by month and allows a ward by ward perspective. All are within the expected norms for each area.

Trust Mortality distribution by area Nov 17 to Dec 19

Area	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	
AINSLIE	1	0	1	4	4	0	1	1	2	1	4	3	3	2	2	1	2	1	0	1	2	4	1	1	5	2	
ALLERTON	3	4	5	2	6	10	6	4	5	3	4	4	3	6	0	4	7	4	8	4	5	4	3	9	3	7	
BRIXHAM	1	3	2	1	1	2	1	1	3	0	3	0	1	0	0	1	4	1	0	1	0	0	2	1	1	0	
CHEETHAM HILL	15	19	12	10	11	8	12	9	8	10	13	9	9	7	13	18	11	8	11	11	11	11	5	9	8	6	
CROMIE	3	3	8	8	9	2	2	2	3	1	1	2	3	6	1	2	5	4	4	5	2	2	4	4	5	6	
DART	2	0	1	2	0	3	1	1	3	1	2	1	2	2	2	2	5	0	3	1	1	1	2	2	2	1	
DAWLISH	3	0	4	3	3	3	4	4	1	0	0	1	1	5	6	3	3	3	2	0	0	5	2	4	0	2	
DUNLOP	4	10	6	7	7	5	3	8	3	6	7	2	6	3	6	5	4	7	5	5	4	3	5	7	5	9	
EAU3	11	7	9	7	4	9	6	7	10	5	7	5	0	3	12	5	5	8	1	6	10	13	8	6	7	6	
EAU4	5	8	7	10	11	12	2	7	6	3	7	8	8	8	6	5	5	7	6	8	8	8	3	5	15	11	
ELLA ROWCROFT	0	1	1	0	0	1	1	2	2	0	0	0	2	0	1	1	1	0	1	2	1	0	1	0	0	0	
FORREST	2	3	5	3	2	4	2	0	1	1	2	3	0	2	3	5	1	2	0	1	3	1	0	1	2	2	
GEORGE EARLE	10	9	14	10	14	6	16	9	10	7	9	13	11	16	17	12	11	11	8	12	9	5	10	7	14	16	
INTENSIVE CARE UNIT	9	12	13	12	6	10	8	6	8	5	8	13	6	4	9	6	6	10	10	9	11	11	10	7	10	11	
MIDGLEY	9	8	12	13	8	11	8	10	8	5	6	17	9	10	11	9	14	10	9	9	11	11	9	8	10	17	
SIMPSON	6	4	6	9	3	9	4	9	10	6	9	9	8	8	10	9	7	10	6	6	7	10	8	6	2	12	
TEIGN WARD	3	3	1	3	3	2	1	1	0	3	0	2	3	2	3	1	2	1	3	3	2	2	1	2	0	1	
TEMPLAR WARD	4	2	1	5	2	1	3	1	3	2	2	5	3	2	2	1	1	0	1	2	1	2	3	5	4	6	
TORBAY CORONARY CARE BEDS	4	1	3	3	1	3	1	2	2	0	2	2	0	1	3	0	2	1	1	2	0	0	1	1	4	1	
TURNER	6	6	8	8	3	9	5	13	5	5	3	6	5	10	8	6	2	8	9	5	7	6	7	7	6	8	
Grand Total	**103**	**104**	**124**	**124**	**99**	**110**	**87**	**97**	**93**	**64**	**90**	**105**	**85**	**98**	**121**	**99**	**104**	**99**	**99**	**95**	**97**	**100**	**86**	**94**	**104**	**125**	

Appendix 3

Dr Foster Alerts Dashboard

Dr Foster utilises an alerting system, as below. Triggers are raised when the expected number is exceeded by the actual number and Dr Foster also provides a guide should an alert occur. In the first instance the coding on each patient is looked at and amended as necessary, second to this is a notes review to confirm cause of death and coding. With the current dashboard, Intestinal infection, Pulmonary heart disease, Cardiac failure are new and will be reviewed as per the instructions of the MSG.

Relative risk & CUSUM alerts

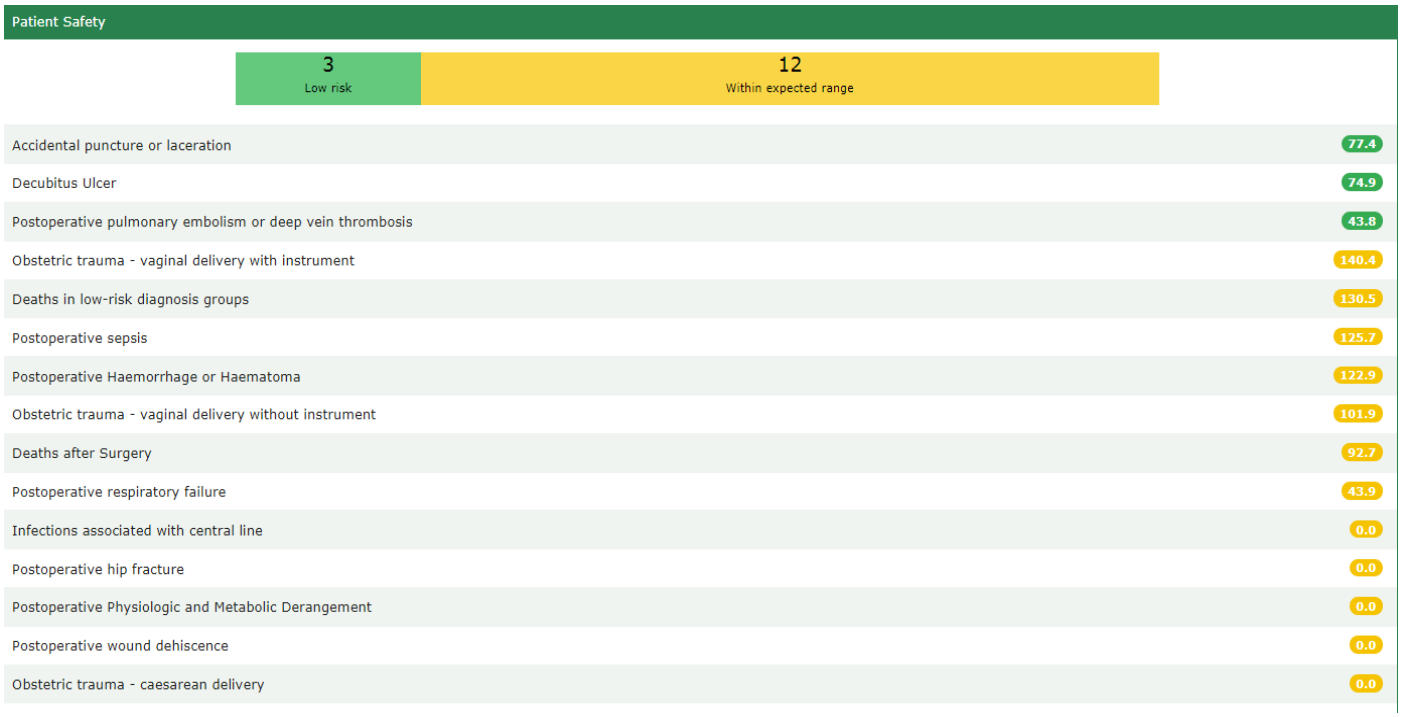
Title	CUSUM	Vol	Obs	Exp	%	Relative risk
All Diagnoses	**13**	**78138**	**1160**	**1145.5**	**1.5**	**101.3**
HSMR (56 diagnosis groups)		29543	974	904.7	3.3	**107.7**
Acute and unspecified renal failure	1	214	29	19.1	13.6	**151.9**
Congestive heart failure, nonhypertensive		505	63	48.4	12.5	**130.2**
Coronary atherosclerosis and other heart disease	1	880	13	5.9	1.5	**221.7**
Essential hypertension	1	77	1	0.1	1.3	959.8
Genitourinary congenital anomalies	1	29	1	0.0	3.4	3095.2
Hepatitis	1	16	1	0.2	6.3	455.5
Intestinal infection		740	19	10.3	2.6	**185.0**
Menopausal disorders	1	60	1	0.0	1.7	3601.1
Nonmalignant breast conditions	1	62	1	0.1	1.6	1014.7
Other congenital anomalies	1	45	1	0.1	2.2	949.4
Other haematologic conditions	1	38	1	0.1	2.6	822.6
Other perinatal conditions	1	264	4	1.8	1.5	228.5
Parkinson's disease	1	16	1	0.6	6.3	155.3
Peritonitis and intestinal abscess	1	23	5	2.7	21.7	182.4
Pulmonary heart disease	2	195	18	8.5	9.2	**212.4**

Appendix 4

Dr Foster Patient Safety Dashboard

These Patient Safety Indicators are taken from Dr Foster and are adapted from the set of 20 devised by the Agency of Healthcare Research & Quality (AHRQ) in the US. The AHRQ developed its indicators after extensive research and they have the benefit of being based on routinely available data which in turn are based on procedure codes used in the NHS.

The data was pulled on the 9th jan 2020, 12 indicators are within the expected norm with 3 are in the low risk category



Appendix 5

Mortality Dashboard of the deaths reviewed this quarter

All learning disability deaths are refered to the CCG for LeDeR

Total Deaths Reviewed by Mortality Methodology Score

Score 1 Probably avoidable			Score 2 Possibly avoidable but not very likely (less than 50:50)			Score 3 Not avoidable		
This Month	0	0.0%	This Month	1	4.5%	This Month	21	95.5%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	2.9%	This Quarter (QTD)	68	97.1%
This Year (YTD)	3	1.1%	This Year (YTD)	16	5.8%	This Year (YTD)	259	93.2%

Of all the deaths reviews and cases taken to the Serious Adverse Events group, the following are identified as possible themes for learning. They may have had no impact on the case but have been identified as action points. The MSG group will discuss and action further as necessasy

Fluid balance not complete correctly	Use of Daily Safety Briefs
Use of Hospital passport	Using LD Nurse specialists to help in the care
Ward Skill Mix– balancing bank with exisiting staff	Raising awareness of different types of insulin
Electronic foetal monitoring stickers	Escalting vertically rather than sideways
Timely use of TEP form	Femoral Artey lines to be made more available

Glossary of Terms

HSMR (Hospital Standardised Mortality Rate) - the case-mix adjusted mortality rate relative to the national average.

- **Relative Risk (RR)** - The ratio of the observed number of negative outcomes to the expected number of negative outcomes. The benchmark figure (usually the England average) is always 100; values greater than 100 represent performance worse than the benchmark, and values less than 100 represent performance better than the benchmark. This ratio should always be interpreted in the light of the accompanying confidence limits. All HSMR analyses use 95 % confidence limits.

CUSUM Alerts - CUSUM is short for 'cumulative sum'. The charts show the cumulative sum of the differences between expected outcomes and actual outcomes over a series of patients. The total difference is recalculated for each new patient and plotted on a chart cumulatively (i.e. where one patient's difference ends the next one starts). Alerts are designed to signal that a pattern of activity appears to have gone beyond a defined threshold. They indicate a series of events that have occurred that are sufficiently divergent from expectations as to suggest a systematic problem. Alerts are triggered when the CUSUM statistic passes through a set threshold. This is shown graphically on the charts by a black cross on the threshold. Once an alert has been triggered the chart is re-set to the mid-way point. This will mean that another run of negative outcomes compared with expected outcomes will trigger an alert in a shorter timescale. The threshold value determines when the CUSUM graph is deemed to be out-of-control (i.e. higher or lower than the benchmark). At this point an Alert is raised and the CUSUM value is reset to half the threshold. The value selected affects the probability that an Alert is a False alarm and the probability that a real alarm is successfully detected. A high threshold is less likely to trigger false alarms but is more likely to miss a genuine out-of-control condition, and vice versa for a low threshold. For example, if chosen "Maximum (99.9%)" the system will select the highest threshold which corresponds to a False Alarm Rate (FAR) that is less than or equal to 0.1% given the annual volume and expected outcome rate of the analysis. With that threshold, only 0.1% of hospitals with in-control outcome rates (i.e. equal to the benchmark) will alert

Charlson Index of Comorbidities
Co-morbidity is assigned to the spell from assessing the secondary diagnoses codes, that are coded in the episode of care used to derive the primary diagnosis. In majority of cases this will be the first episode of care (on admission to hospital), however, where the primary diagnoses in the first episode of care is an R code, the system will look to the second episode of care to identify a clearer diagnosis, should one be available. In that case the secondary diagnoses of the second episode will be used. The Charlson Index of comorbidities is used both for the HSMR and the SHMI.

The Standardised Hospital Mortality Indicator (SHMI) is the ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method, year index, Charlson Comorbidity Index and diagnosis grouping. The cumulative risk of dying within the spell for each patient within the selected group gives the number of expected deaths.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Assurance framework for Seven Day Hospital Services			Meeting date: 5th February 2020
Report appendix	N/a		
Report sponsor	Medical Director		
Report author	Acting Medical Director		
Report provenance	• Reported to the Integrated Performance Committee November 2019 • Monitoring Process • Urgent and Emergency Care Improvement Groups • Torbay and South Devon A & E Delivery Board		
Purpose of the report and key issues for consideration/decision	This is a report on the progress made by Torbay and South Devon Foundation Trust in relation to seven-day hospital services (7DS). This programme supports providers of acute hospital services to tackle variation in outcomes for patients admitted to hospitals in an emergency, at the weekend and during weekdays. This work is built on 10 clinical standards (CS) developed by the NHS Services, Seven Days a Week Forum in 2013. Four of these clinical standards were made priorities for delivery to ensure patients admitted in an emergency receive the same high-quality initial consultant review, access to diagnostics and interventions, and ongoing consultant-directed review at any time on any day of the week. In addition to the 7DS clinical standards for all emergency patients, there are 5 urgent network clinical services which have been given priority: hyperacute stroke, paediatric intensive care, STEMI heart attacks, major trauma and emergency vascular surgery. The Trust has reported on hyperacute stroke and STEMI heart attacks. Other urgent networked clinical services are provided by neighbouring Trusts.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	The Trust Board is asked to note the contents of the report and the risks and assurance highlighted. The Trust Board is asked to approve the monitoring of 7-day services continues as described with reporting to the Board to be undertaken on a bi-annual basis.		

Summary of key elements	
Strategic objectives supported by this report	

Safe, quality care and best experience	Y	**Valuing our workforce**	
Improved wellbeing through partnership		**Well-led**	Y

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework		**Risk score**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission		**Terms of Authorisation**	
NHS Improvement	**Y**	**Legislation**	
NHS England	**Y**	**National policy/guidance**	**Y**

Report title: Assurance framework for Seven Day Hospital Services		Meeting date: 5th February 2020
Report sponsor	Medical Director	
Report author	Acting Medical Director	

1.0 Introduction

Since February 2019, three major workgroups have been developed to direct quality improvement in urgent and emergency care:

a) The Emergency Floor Group, is Chaired by Dr Catherine Blakemore and has focused work on: -

   i. Emergency front door work providing a rapid initial handover of ambulance patients (80% within 15 minutes) and rapid assessment by a clinician (median time less than 60 minutes) together with the introduction of an ED safety checklist to ensure a high standard of care.

   ii. Internal Professional Standards between ED and other Specialities. This involves agreement that there should be minimal delay between referral from the Emergency department and assessment by the specialist team.

   iii. Real Time Medical Take requires a non- ambulatory assessment area on EAU3 which remains open to patients referred by GPs and ED for speciality assessment. It is essential that patients who require inpatient care are moved rapidly from the EAUs to definitive inpatient beds to enable rapid assessment to continue.

   iv. Same Day Emergency Care occurs on the ambulatory unit and was assessed in October 2019 as providing an excellent service achieving our target of providing SDEC at least 12 hours a day 7 days a week with a reduction in admission conversion rate. Work on providing SDEC for patients with pulmonary embolus, atrial fibrillation and community acquired pneumonia continues to develop as part of our CQUIN target.

b) The Wards Group is Chaired by Rhoda Allison and has focused work on: -

   i. Embedding SAFER ward processes including regular senior review and early discharge of inpatients to enable early transfer of patients assessed on the emergency floor who require a definitive inpatient bed before 10am.

   ii. Criteria Led Discharge and Expected Date of discharge to be agreed with patients and carers by a multi-disciplinary team with 24hrs of admission (Clinical Standard 3). In particular, identification of patients who could potentially go home at weekend must be identified on the Friday ward round.

   iii. Red to Green to identify barriers to discharge and will set internal professional standards around the timeliness of ward processes such as availability of diagnostics (Clinical Standard 5) and consultation by other medical teams.

   iv. Weekend processes includes a significant improvement initiative by Dr Andy Griffiths to develop better co-ordination of the clinical team at weekends to prioritise care and enable timely discharge. Clinical Standard 8 ensuring that

emergency inpatients admissions have appropriate senior review will be addressed by this workgroup.

c) The Home First Group is Chaired by Dr Mathew Fox and has focused work including:

   i. Enhanced intermediate care to ensure that the community team works together to extend care in the community including reablement and discharge to assess processes.

   ii. Improved transport support to enable more rapid transport of GP referred patients using our patient transport service.

   iii. Engaged and supported care homes.

   iv. Development of a community and acute frailty service with assessment of ED patients by a Rockwood score and an ambition to cohort frail patients requiring less than 48hrs inpatient stay in a specialist unit on an Acute Frailty Pathway. The existing multi-disciplinary joint emergency team (JET) will have their offer at ED enhanced by dedicated consultant support.

   v. Exploring admission avoidance by working with South West Ambulance Service Trust to enable crews to select the best service for urgent patients such as intermediate or ambulatory care rather than ED. A MIDOS application has been updated to enable crews to identify patients suitable for ambulatory care. The discharge hub will extend opening to 7 days a week to enable complex discharge on every day. Clinical Standard 9 will be reviewed by this group.

d) A number of other workgroups include enhanced support to care homes from the community teams including GP visiting and improved visibility of care home bed availability using a Strata IT system with the discharge hub. The red bag initiative will improve communication between care homes and hospital and 45 Trusted assessors are now work with care homes to facilitate rapid discharge.

There are monthly meetings of the South Devon A&E Delivery Board where work from the above groups is co-ordinated with input from strategic partners including primary care, SWAST, CCG, NHS 111, Devon doctors, DPT (Liaison psychiatry) (Clinical Standard 7) to develop an integrated approach to urgent and emergency care. In addition, there is a two weekly Urgent and Emergency Care programme board to provide a strategic overview of progress.

2.0 Discussion

Steady progress has been made in the assessment of all emergency patients by a consultant within 14 hours of admission since 2016. The target of 90% has not been achieved but progress is in line with that achieved by other Trusts in England. Work to drive improvement in this target is ongoing as part of the improvement to emergency assessment. This includes real time medical assessment and visibility of waiting times for consultant assessment with the medical O drive. Further work aims to optimise the transfer of patients' care between the Emergency Department and Specialist teams.

The Trust provides good support to the emergency take with diagnostic services and consultant directed interventions.

Particular improvements over the last 6 months include on the emergency floor a continued development of same day emergency care with a good external review in October 2019. On the wards, the weekend process work in August and September has led to improvement in weekend discharges and improved co-ordination of clinical teams. In the community, the extension of the discharge hub to 7 days a week and development of Trusted assessors enable timely discharge.

3.0 Options

This report is the third of a new Board Assurance Process. A further report to assess progress against standards is planned for June 2020 Board.

4.0 Summary of Key Elements

The report provides a summary of the progress in the development of 7 day working since June 2019:

- Assessment of all emergency patients by a consultant within 14 hours of admission can be monitored in real time in acute medicine (“O” drive) and General Surgery (Clinical Portal). Between April and September this year 69% of patients were seen by a consultant physician on the post take ward round within 14 hours of referral.

- Consultant directed diagnostic tests (CS5) were available within an appropriate time scale for emergency patients in 94% of cases achieving the national target.

- Consultant directed interventions (CS6) such as critical care, interventional radiology and interventional endoscopy were available to emergency patients 7 days a week in 100% of cases.

- Ongoing consultant review of patients with high dependency needs were provided twice a day in 100% of patients assessed.

- Consultant job plans in General Surgery, Trauma and Orthopaedics and Paediatrics should enable consultant review of all emergency patients every day. In medicine, consultant job plans enable daily consultant review of patients on the Emergency Floor; ED, EAU3 and EAU4 and AU. However, weekend review of patients on the inpatient medical wards is potentially available between 12:00 and 14:00 although this depends on the demand on physician time by the acute assessment wards. This potential conflict can contribute to low discharge rates at weekends and consequent problems with emergency flow.

- Management of STEMI heart attacks achieved over 90% compliance with all four of the priority clinical standards.

- Management of hyperacute stroke did not meet the 90% target for standards 2 and 8. Management of hyperacute stroke is subject to an STP development.

5.0 Conclusion

Development of 7-day services work is embedded in the Trusts’ overall improvement project for urgent and emergency care.

For the next six months focus will continue to provide flow from the emergency assessment areas to wards or home to enable rapid clinical assessment to continue to function. On the wards the

SAFER process still requires ownership by the whole multi-disciplinary team. The acute frailty service may require further resources to realise its potential.

The organisational structure of the management of urgent and emergency care has changed since the introduction of the new organisational structure for the ICO on 1st April 2019. The main responsibility for urgent and emergency care sits within the Newton Abbot Integrated Service Unit under the South Devon System. Within this structure, three main workgroups have been developed to produce quality improvement in urgent and emergency care as documented above. The four priority clinical standards (2,5,6,8) are all mapped to quality improvement projects within the three main workgroups. Whilst challenges in delivery of the 14-hour target (CS2) and medical ward consultant assessment at weekends (CS8) remain, there are now named leads to address these under the above governance structure.

The expected outcomes of 7DS recommendations support and are linked strongly to our urgent care performance targets thus the 7DS compliance will be combined with regular urgent care performance metrics in the Integrated Performance Report.

6.0 Recommendations

The Board is asked to note this new assurance process and to receive a further report in June 2020 as part of full implementation.

7 Day Hospital Services Self-Assessment

Organisation	**Torbay and South Devon NHS Foundation Trust**
Year	**2019**
Period	**Autumn/Winter**

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Evidence Source 1. Acute Medicine: The "O drive" system provides a real time dashboard of the acute medical take. The data was accessed for the six month period April to September 2019. An average of 456 patients were referred to medicine a week (65 patients a day). A consultant led, post take ward round was recorded for 69% of patients within 14 hours. Consultant led post take ward round within 14 hours occured in 93% of cases for patients on the ambulatory unit (AU) and 57% of patients on the non ambulatory assessment units. For patients admitted to speciality wards a review within 14 hours was recorded in 42% of cases. More patients were recorded as reviewed by a consultant with 14 hours on weekdays (71%) compared to weekends (60%). The "O drive" system, whilst imperfect, does enable a real time dashboard of the acute medical take and enables a RAG rating triage of patients enabling early senior review of the most acutely unwell patients. The O drive system is not an integrated electronic patient record thus consultant assessment may not be recorded or recorded later than the time of review. Furthermore, the start time recorded on the O drive is the time of referral to medicine, frequently this will be earlier than the time of admission recorded on our patient administration system. Same Day Emergency Care (SDEC) occurs on the ambulatory unit. In October 2019 an independent review of SDEC by the Ambulatory Emergency Care Network included a 50 case file review demonstrating that 95% of patients were treated in the correct location. In August the surgical team recruited two new fellows allocated to the Ambulatory Unit with dedicated diagnostic ultrasound slots. There were good examples of medical and surgical SDEC with demonstration of good links to community services. Acute General Surgery General Surgery introduced a new Clinical Portal System to manage emergencies in June 2019. This enables tracking of urgent patients managed by ambulatory surgery togethr with inpatients	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	This standard was audited in September 2016. Sixty seven consultants managing emergency patients in the Trust responded to this survey. Microbiology, CT, ultrasound and upper GI endoscopy were rated as always or usually available by the majority of consultants. All ICU consultants are able to provide a basic echocardiogram as can the on-call interventional cardiology consultant. The technician led echocardiography service is looking to extend to provide 7 day service. MRI is available out of hours but would require discussion with on call radiology to organise.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available off site via formal arrangement	
		Upper GI endoscopy	Yes available on site	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available off site via formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available off site via formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	This standard was audited in September 2016. Sixty seven consultants managing emergency patients in the Trust responded to this survey. Critical Care, cardiac pacing, emergency general surgery, interventional endoscopy, stroke thrombolysis are available on site both within and out of hours. Interventional radiology is provided by a well established network with colleagues from RD&E. Renal replacement therapy can be provided in ICU by haemofiltration. Haemodialysis is available by a network arrangement with RD&E. Emergency radiotherapy is available but rarely used and would require organisation.	Emergency Renal Replacement Therapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Patients on intensive care are seen twice daily by a consultant (achieved 100% in April 2018 audit). Patients admitted as an emergency to an inpatient ward should receive a daily review by a consultant unless this has been delegated to another competent member of the multidisciplinary team on the basis that this would not affect the patients' care pathway. TSDFT achieved this standard on the April 2018 audit on weekdays in 74% of cases and at weekends at 49 % of cases. Evidence Source 1 Consultant Job plans. Consultant job plans in General Surgery, T&O, paediatrics and obstetrics and gynaecology provide for consultant led ward rounds of emergency patients during weekdays and weekends. In medicine, consultant ward rounds occur daily on all wards during weekdays. At weekends in medicine daily consultant assessment occurs on the acute assessment areas (EAU3 & EAU4) and ambulatory care. On the remaining medical wards, consultant job plans provide for a 2 hour period midday for consultant assessment. Evidence Source 2 Local Clinical Audit. A project to improve weekend working commenced in August 2019. All inpatients are assessed on a Friday by multi-disciplinary teams and care plans developed including clinical criteria for discharge. Patients who could be potentially discharged over the weekend are collated by the Control room on Friday afternoon. On Saturday, improved co-ordination of the junior and senior medical staff, phlebotomists, pharmacy and nursing teams was undertaken by the clinical site team. Results: Since commencement of the project, weekend discharge numbers have improved from 170 on 2/8/19 to a peak of 225 on 13/9/19 with a steady trajectory of improvement. Clinical co-ordination on a Saturday has led to better prioritisation of the work of clinical teams. The Friday handover sheets and in particular criteria-led discharge can enable weekend discharge without further medical input	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Standard 1. Although shared decision making is implicit for patient and clinician interaction, it is rarely explicitly recorded in the notes. Treatment escalation plans are an exception to this. The use of printed patient information sheets is rarely recoded for emergency patients. Standard 3 Work is required to identify the members of the multidisciplinary team needed to provide a holistic assessment of emergency patients within 24hrs of admission as an emergency patient. This is addressed a work group which seeks to embed the SAFER principles onto all wards. Standard 4. Handover is led by competent senior decision makers in the major acute specialities daily. Work is required to provide assurance that the handover process is accurately documented. Standard 7. Liasion psychiatry is available for both adults and children. The Liaison Psychiatry service has focused on their hour response times to ED. The latest flash report shows that despite staff shortages the hour target to ED was achieved in just below 80% (Oct 2019). The team continues to comply with the 24 hour target to the hospital wards achieving 88% within 24 hours. The Psychiatric Liaison team has worked with ED to reduce attendance in an identified cohort of patients who attend ED frequently with mental health problems. Standard 9. The development of community support services is a major component of the emergency offer. This includes development of integrated care and work with care providers and community hospitals. Recent developments include the discharge hub which is expanding to work 7 days a week over the winter and work to strengthen community care. The Home First workgroup has projects with named leads and support for i) Developement of the Frailty Service ii) Admission avaoidance iii) enhanced intermediate care iv) transport v) community support on discharge. Standard 10. Outcomes of emergency patients are monitored by a weekly multi-disciplinary team and a two weekly strategic meetings.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
This was audited by a 10 case note review of urgently admitted STEMI heart attack and stroke patients from March 2017. Improvements have occurred in acute medical assessment over the last 2 years. Acute Stroke is assessed by the national SSNAP audit data. There is a seven day specialist stroke nurse availability and 91.4% of patients presenting with acute stroke were assessed by a specialist nurse within 24 hours of "clock start" slightly above national averages. There are three stroke consultants at present but there is not a specialist stroke consultant rota. Thus, 69.3% of stroke patients were seen by a stroke consultant within 24 hours of "clock start", below a national average of 83.9% (April - June 2019 data).

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Care Quality Commission update			Meeting date: 5th February 2020
Report appendix	Appendix 1: Themes of CQC ratings Appendix 2: Board well-led self-assessment to NHSI framework		
Report sponsor	Chief Nurse		
Report author	Quality and Compliance Manager		
Report provenance	CQC Assurance Group		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to maintain the Board's awareness of current CQC matters and provide early signalling of areas requiring action to improve the healthcare service provided.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	This summary Board Report is for information only.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	✓	**Valuing our workforce**	
Improved wellbeing through partnership		**Well-led**	✓

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework		**Risk score**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	✓	**Terms of Authorisation**	
NHS Improvement		**Legislation**	
NHS England		**National policy/guidance**	

Report title: Care Quality Commission update		**Meeting date:** 5th February 2020
Report sponsor	Chief Nurse	
Report author	Quality and Compliance Manager	

1 Introduction

1.1 Aim

This paper provides the following for the TSDFT Board:

- An update on previous TSDFT Care Quality Commission (CQC) inspections (section 2.1)
- An update on forthcoming TSDFT CQC inspections (section 2.2)
- An update on CQC's ongoing monitoring of the Trust (section 2.3)
- An update on TSDFT's CQC registration activity (section 2.4)
- A summary of progress on TSDFT Board's well-led self-assessment (section 2.5).

1.2 Purpose

The purpose of this report is to maintain the Board's awareness of current CQC matters and provide early signalling of areas requiring action to improve the healthcare service provided.

2 Discussion

2.1 Previous CQC inspections: 2018 well-led and core services

2.1.1 ASW Assurance internal audit

As part of the 2019/20 Audit and Assurance Plan, approved by the Audit Committee, ASW Assurance has reviewed the Trust's CQC Improvement Plans implemented in response to the CQC inspection report published in May 2018.

The objective of this review was to provide the Trust with assurance that there are adequate controls in place managing the compliance with the CQC regulations, through identifying the implementation status of a sample of 'must do' and 'should do' recommendations.

The overall assurance opinion from the review on the design and operation of controls is 'Significant', defined as 'controls are well designed and are applied consistently; any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives; examples of innovation and best practice may be in evidence."

The audit report has one recommendation, that the CQC and Compliance Assurance Group (CQCCAG) should consider introducing a follow up process to re-visit actions completed as part of either the Requirement Notice Action Plan or the Should Do Action Plan in relation to the May 2018 CQC Inspection Report.

This finding is being addressed as described in section 2.1.2 below.

2.1.2 Requirement Notices

As previously reported to the Board, the action plan towards addressing the ten Requirement Notices from the CQC's Inspection Report published in May 2018, is considered closed by the CQC and Compliance Assurance Group (CQCCAG). However, the group intend to revisit the action plan in the February meeting to seek assurance that compliance is being sufficiently maintained and monitored through the defined business as usual routes.

2.1.3 Should Do Improvements

The CQC's Inspection Report published in May 2018 from the inspection of five core services and the well-led assessment of TSDFT listed 47 "Should Do Improvements". The status of the actions towards addressing these improvements is as follows:

- Overall Trust, 7 of 9 are closed;
- Maternity, all 12 are closed;
- End of Life, 9 of 10 are closed;
- Outpatients, all 5 are closed;
- Community End of Life, all 6 are closed, and
- Community Children and Young People, 4 of 5 are closed.

Of the remaining 4 open "Should Do Improvements" none are RAG-rated as red, where "red" is requiring additional unplanned intervention. The Should Do Improvement action plan is regularly reviewed at the monthly CQCCAG meeting. The trajectory for closure is end of February 2020 and a review of the evidence.

2.2 Forthcoming inspections

2.2.1 Well-led inspection programme

The routine Provider Information Request (PIR) was received from the CQC on Friday 29th November 2019, accompanying the request was a letter with notification that the Trust will receive an announced well-led inspection within six months of the letter, prior to which there will be unannounced inspection visits of at least one core service.

The Trust's response to the PIR, comprising the three completed CQC workbooks:

- All providers;
- Additional acute questions; and
- Additional community questions

187 documents were submitted to the CQC on 20th December 2019, meeting the CQC's deadline. Both intermediate deadlines were also met, which required the Trust to provide elements of the PIR by 3rd and 10th December.

During the PIR, the CQC identified that TSDFT has one Mental Health core service, Substance Misuse, and on 11th December issued a request for a fourth workbook to be completed (additional mental health questions) by 10th January 2020; this submission deadline has also been met.

Data queries on the PIR submission were received from the CQC on Tuesday 31st December 2019, the response to which was submitted on Monday 6th January 2020 to time. On 9th January 2020, the CQC confirmed the stages of submission and validation are complete and expressed thanks for a responsiveness rendering the process 'very smooth'. The information has now been handed on to the CQC analysts for review, which may potentially result in further information requests.

The support from the Clinical Effectiveness department throughout December 2019 in meeting the PIR standard, but challenging, three-week deadline should be acknowledged.

Although the PIR letter from the CQC stated the well-led inspection will be within six months, the best estimate of when this will most likely happen, according to CQC publicised timeframes and experience, is that the unannounced core service inspections are likely to be around February, but could be through March and into April. The announced well-led inspection is likely to be March through to April are possible.

The Use of Resources (UoR) assessment by NHS Improvement (NHSI) is scheduled for Wednesday 12th February 2020. NHSI's brief guidance for providers document dated February 2018, states that the UoR assessment:

- is designed to improve understanding of how effectively and efficiently trusts are using their resources – including their finances, workforce, estates and facilities, technology and procurement – to provide high quality, efficient and sustainable care for patients;
- will ideally occur before the CQC's well-led inspection; it is anticipated that the UoR will occur in the weeks before a well-led inspection, but preferably not at the same time as a core services inspection;
- will generate a report and rating which will be published by the CQC.

The CQC website states that the CQC uses the UoR rating to award trusts a combined rating at the overall trust level, through aggregating the UoR rating with the CQC's five trust-level quality ratings for the key questions of safe, effective, caring, responsive and well-led.

The UoR pre-assessment information submission, preparation for the visit and the visit itself are being managed by TSDFT's Finance team.

2.2.2 Preparation

A document titled "Preparing for a CQC inspection: An introduction and toolkit for team leaders and their teams" has been created and issued to support teams and staff in being inspection ready. The document outlines what to expect from a CQC inspection; top level generic trust information (e.g. values, vision, ISU structure), and questions/checklists to help teams prepare themselves for an inspection. Feedback from staff and managers regarding the document has been very positive. The document can be found on the CQC pages on ICON.

Teams/services are producing one-page "Achievement summaries" as infographics or newsletters highlighting achievements since the last CQC inspection to help raise awareness of the progress and great work being done, within and across teams. These achievement summaries can be found on the CQC pages on ICON.

The unannounced CQC visit communications protocol is being updated with recent changes in personnel. The general process is for the person receiving the unannounced visit to alert 1) the Chief Executive's office, who will inform the Chief Executive, Chairman, Executive Directors and a member of the Patient Safety team, and 2) the Switchboard, who inform the system directors by phone. The Patient Safety team will email out a brief alert message to these groups and the Associate Directors, Company Secretary and Pharmacy Director.

A 'CQC Preparation Plan' for the well-led programme of inspections 2020, has been created.

In response to a request from the Board, a summary of themes of the ratings given to providers by the CQC is in Appendix 1.

2.2.3 Other potential inspections

As well as the well-led programme of inspections (section 2.2.1), TSDFT may receive a focused announced or unannounced inspection at any time, in or out of hours. For example, the CQC have stated that they intend to repeat their programme of Emergency Department focussed unannounced inspections in winter 2019/2020, following the programme run in winter 2018/2019.

In addition, as reported in the last Board CQC update paper, in Autumn 2019 TSDFT were made aware that a Joint Targeted Area Inspection(s) of Children's Mental Health, Devon was expected by the end of 2019. These inspections are undertaken by Ofsted, the CQC, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service (HMICFRS) and Her Majesty's Inspectorate of Probation (HMI Probation). At the time of writing (20th January 2020), this inspection has not yet occurred.

The Special Educational Needs and Disabilities (SEND) Torbay inspection is also yet to be performed, Torbay being one of the last regions in the country to receive this inspection by CQC and Ofsted.

2.3 CQC's ongoing monitoring

2.3.1 CQC-TSDFT Engagement meetings

Engagement meetings are held quarterly between TSDFT and the CQC, as part of the CQC's ongoing monitoring of providers, in-line with the CQC's 2016-2021 strategy. These meetings are documented with brief notes in the CQC's Engagement Meeting Record Tool, a final copy of which is sent by the CQC to NHS England and NHS Improvement.

The last meeting was held on Wednesday 27th November 2019 at Torbay Hospital and was attended by Amy Bance (CQC Inspection Manager) and Tracy Hipkin-Wale (CQC Inspector, and TSDFT relationship holder), and included an interview with the Medical Director, Rob Dyer, and a focus group for Critical Care core service staff. No areas of significant or urgent concern were fed back by the inspectors.

The next CQC-TSDFT Engagement meeting is on Wednesday 29th January 2020, when Amy Bance and Tracy Hipkin-Wale will be joined by a CQC Mental Health inspector, Evan Humphries. The Chief Operating Officer will be interviewed by the Inspector and Inspector Manager, and the Substance Misuse service manager and the Medical Director, Rob Dyer, will be interviewed by the Mental Health Inspector. There will be four focus groups: 1) clinical leads (consultants) from End of Life, Critical Care and Surgery core services; 2) service leads from all Community core services; 3) admin and finance staff; and 4) AHPs.

2.3.2 CQC Insight

The CQC Insight tool is designed to make CQC's activity more intelligence-driven as outlined in their strategy for 2016-2021. The Insight dashboard primarily enables CQC staff to monitor the quality of care and focus resources on where the risk is greatest.

Point-in-time extracts of TSDFT data on the CQC Insight tool are made available to TSDFT approximately monthly. The tool is still being developed by the CQC and it is common to see new measures appear from month to month. Each month the extract report is distributed for teams to check the Trust is already sighted on the measures, and 'new-this-month red flags' compared to the previous month, are highlighted.

The local inspectors use the insight data to inform the agenda for discussion at the Engagement meetings. The December extract has recently been made available to the Board in the Knowledge Base.

2.3.3 CQC follow up on specific events pertaining to services provided by the Trust

As part of the ongoing monitoring of the Trust by the CQC, the local CQC Inspector requests further information on specific events of particular interest relating to services provided by the Trust, such as specific complaints, safeguarding concerns, patient-related incidents, etc. All of these events are routinely managed internally by TSDFT through established processes and governance routes; when the information on the specific events requested becomes available it is passed to the CQC.

The CQC may also request a response from the Trust to feedback received directly by the CQC, in regards to the services provided by the Trust, to which the Trust will provide a timely response.

The number of such requests for further information received from the CQC within the last three months, for each category of event, is shown in Table 1.

Table 1: The number of requests received between 24th October 2019 and 17th January 2020, from the CQC for information on specific events, related to services provided by TSDFT.

Event category	Number of requests
Direct feedback to CQC	4
Complaint to CQC	1
Never Event	0
Safeguarding concerns	4
NRLS	1
RIDDOR	0
Major incident	0

RIDDOR = (Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013; responsibility for which has been assumed by the CQC from the HSE); NRLS = National Reporting and Learning System.

In addition, the Trust has proactively reported to the CQC one never event of wrong-side excision.

2.4 CQC Registration

2.4.1 Torbay 0-19 Partnership

It was communicated in the last Board CQC Update paper that the Trust had received confirmation from the CQC that the current status of the Trust's registration with the CQC supports the services provided as part of the new Torbay 0-19 Partnership contract and therefore no changes are required to the Trust's registration status. The Statement of Purpose update highlighting the new services and the subcontractors that the Trust is engaged with in relation to these services submission was delayed due to the PIR submission, and will now be submitted by the end of January 2020.

2.4.2 Registered Manager review

The Registered Manager status for TSDFT has been reviewed and a change required for the regulated activity of Personal Care at Newton Abbot Hospital has been identified. An application to make this change will be made in February 2020.

2.5 TSDFT Board's well-led self-assessment

At the Board Development Session in November 2018, the Board discussed and self-assessed the Trust against a CQC rating of Outstanding for the eight key lines of enquiry (KLOEs) in the NHSI/CQC well-led framework dated June 2017. The Board discussed and agreed the: current state; evidence for the current state; gaps to Outstanding, and RAG-rated where "Red" is little or no evidence to support an Outstanding rating, "Amber" is some evidence or more assurance is required, and "Green" is sufficiently assured. No KLOEs were self-rated as "Red".

"Gaps" were defined as areas requiring additional strengthening to bring the Trust up to a CQC self-assessment rating of Outstanding. Progress made towards narrowing the

gaps identified in the self-assessment has been in part facilitated by the development of the Torbay and South Devon Systems, which includes increased clinical leadership capacity.

In May 2019, the Executive Directors undertook to review progress towards closing the "gaps" to outstanding previously identified, with input from the System Directors and the Executive Director Deputies; progress updates were compiled in June 2019. The focus is currently being placed on gaps that were red-rated at this progress review.

The TSDFT Board's well-led self-assessment is presented in **Appendix 2**.

3 Conclusion

This report has provided an update to the Board on TSDFT's current and recent CQC inspection, monitoring and registration activity. A summary of a key CQC review publication has also been provided.

4 Recommendations

This summary Board Report is for information only.

Appendix 1: Themes of CQC ratings

The CQC have published the characteristics for the ratings given to providers (Table 1).

Table 1: Ratings characteristics for healthcare services (Source: compiled from CQC's publication "Key lines of enquiry, prompts and ratings characteristics for healthcare services, June 2018", see for more detail.)

Outstanding	Good	Requires Improvement	Inadequate
Safe: people are protected from abuse* and avoidable harm. *Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.			
People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.	People are protected from avoidable harm and abuse. Legal requirements are met.	There is an increased risk that people are harmed or there is limited assurance about safety. Regulations may or may not be met.	People are not safe or at high risk of avoidable harm or abuse. Normally, some regulations are not met.
Effective: people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.			
Outcomes for people who use services are consistently better than expected when compared with other similar services.	People have good outcomes because they receive effective care and treatment that meets their needs.	People are at risk of not receiving effective care or treatment. There is a lack of consistency in the effectiveness of the care, treatment and support that people receive. Regulations may or may not be met.	People receive ineffective care or there is insufficient assurance in place to demonstrate otherwise. Normally, some regulations are not met.
Caring: the service involves and treats people with compassion, kindness, dignity and respect.			
People are truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.	People are supported, treated with dignity and respect, and are involved as partners in their care.	There are times when people do not feel well-supported or cared for or their dignity is not maintained. The service is not always caring. Regulations may or may not be met.	People are not treated with compassion or involved in their care. There are breaches of dignity and significant shortfalls in the caring attitude of staff. Normally, some regulations are not met.
Responsive: services meet people's needs.			
Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.	People's needs are met through the way services are organised and delivered.	Services do not always meet people's needs. Regulations may or may not be met.	Services are not planned or delivered in a way that meets people's needs. Normally, some regulations are not met.
Well-led: the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.			
The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.	The leadership, governance and culture promote the delivery of high-quality person-centred care.	The leadership, governance and culture do not always support the delivery of high-quality person-centred care. Regulations may or may not be met.	The delivery of high-quality care is not assured by the leadership, governance or culture. Normally, some regulations are not met.

The CQC has published Driving Improvement reports which feature case studies on improving trusts. The CQC's "Driving Improvement: Case studies from NHS trusts" published in June 2017, reports the following key themes from interviews with trust Boards, staff, patients and external stakeholders from eight trusts that had achieved significant improvement in the well-led rating since a previous inspection. Table 2 shows the themes from this review.

Table 2: Themes from trusts achieving significant improvement in being well-led.
(Source: the CQC's website www.cqc.org.uk/publications)

Theme	Finding
Reaction to initial inspection report/rating	Trusts were able to make rapid improvements when leaders viewed our inspection report as an opportunity to drive change.
Leadership	Leaders knew they needed to be visible and approachable in order for staff to feel supported.
Cultural change	Trusts knew that it was not enough to create an improvement plan – they had to engage and motivate their staff to help drive it and move from a culture of blame to one that celebrates success. They also recognised the need to tackle equality and diversity issues relating to staff and patients and in the wider community.
Vision and values	Leaders placed an emphasis on getting to know how staff felt about working at the trust and understood that staff needed to have ownership of the values if they were to be meaningful.
Governance	Addressing problems with governance was a priority for most of the trusts. The right connections needed to be in place from board to ward.
Improving safety	Improving trusts ask questions about the quality of their services.
Patient and public involvement	Taking the views and experiences of patients and the public into account is vital to making improvements
Looking outwards	Trusts pointed to the power of being open with staff and the public
CQC engagement	As well as identifying problems and helping trust develop improvement plans, inspection reports can help to give structure to improvement work as well as giving clinicians and managers the vigour to effect change.

Table 3: Summary of findings from Western Sussex Hospitals NHS Foundation Trust which received the 'royal flush' of ratings from the CQC in an inspection report published October 2019, i.e. outstanding for safe, effective, caring, responsive, well-led and use of resources.

Key question	Finding
Safe	- Patient safety incidents managed very well - Safety monitoring results used exceptionally well and participate in national safety thermometer scheme. - Innovation was encouraged to achieve sustained improvements in safety and continual reductions in harm. - Controlled infection risk well - Staff kept appropriate records of patients' care and treatment - Staff understood how to protect patients from abuse and worked well with other agencies to do so - Service had enough staff with right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. - Staff recruitment was a major challenge however there were systems to ensure match between staff on duty and patient's needs; no areas identified where staffing challenges impacted negatively on patient care - All staff engaged in reviewing and improving safety and safeguarding systems through regular safety and improvement huddles. - Clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. - Service had suitable premises and equipment, with ongoing investment. Historic shortcomings in estates were known and being considered by the board as part of the estates master plan; there was no evidence that less than ideal environments had impacted on patient safety. - Training was a strength of the organisation, providing mandatory training in key skills to all staff. Also a programme of quality improvement training. - Genuinely open culture in which all safety concerns raised by staff and service users were highly valued as being integral to learning and development. - Learning was based on thorough analysis and investigation when things go wrong. - Trust applied duty of candour. - Trust had sustained improvement in level of deaths related in septicaemia. - Sustained track record of safety supported by accurate performance information. Ongoing consistent progress towards safety goals reflected in zero-harm culture.

Effective	- Care and treatment provided based on national guidance and evidence of its effectiveness. - Truly holistic approach to assessing, planning and delivering care and treatment to all service users. - Safe use of innovative and pioneering approaches to care. - New evidence-based techniques were used to support delivery of high-quality care. - Support of staff to understand and meet the standards in the Mental Health Act 1983 (MHA) Code of Practice. - Mental health strategy and good oversight of detained patients care through the safeguarding team. Good collaboration with the mental health trust. - All staff actively engages in activities to monitor and improve quality and outcomes. - Opportunities to participate in benchmarking and peer review were proactively pursued, including accreditation schemes. - Outcomes for service users were positive, consistent and regularly exceeded expectations. - Participation in all relevant national audits and compared local results with those of other services, to learn from. - Staff were committed to working collaboratively and found innovative and efficient ways to deliver more joined-up care. - Holistic approach to planning people's discharge, transfer or transition to other services. - Multidisciplinary team working regularly meeting to agree treatment plans with patients. - Patients had access to full range of therapists many on a seven-day basis. - Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment via an electronic records system.
Caring	- Feedback from service users very positive about the way staff treat people. People talked about staff that went the extra mile and said their care and support exceeded their expectations. - Patients and carers were engaged in service development - Friends and family test response rate was much higher than for comparable trusts which meant there was greater validity to the scores. The trust outperformed most comparable trusts. - Staff cared for patients with kindness and compassion. - Strong, visible person-centred culture. - Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. - Relationships between patients, those close to them and staff were caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. - Staff involved patients and those close to them in decisions about their care and treatment. - Staff provided emotional support to patients to minimise their distress. - Patients could access chaplaincy services to meet their spiritual needs.

Responsive	- Trust planned and provided services in a way that met the needs of local people. The trust worked collaboratively with commissioners, patient representatives and other stakeholders to provide services which considered local priorities and population needs. - There were processes in place to allow for specific services to include patients, including those with protected characteristics, in developments. - People's individual needs and preferences were central to the delivery of tailored services. The trust had guidelines for staff on caring for adult patients with a learning disability in the acute hospital. - Innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. - Services are flexible, provide informed choice and ensured continuity of care. - Systems to support people living with dementia including specialist dementia nurses and modifications to clinical environments to make them more dementia friendly. - Cancer performance was compliant against all of the targets. - Technology was used innovatively to ensure people have timely access to treatment, support and care. - Complaint investigations were comprehensive and had senior oversight from a clinical perspective. All complaints were considered from a safeguarding perspective.
Well-led	- Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care. - Staff spoke highly of their leaders and talked about approachability, visibility and a shared commitment to providing excellent care and treatment for patients - Trust had committed to employing and supporting research and academic development in all professions, reflected in staff engagement with published research and using evidence-based practice. - Trust, and each division, had a clear vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The trust had set its vision and strategic objectives in collaboration with all stakeholders. - Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. - Systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. - Culture of identifying and solving problems using a quality improvement methodology. - Commitment to research activity with many active projects and published papers. - Effective systems for identifying risks, planning to eliminate or reduce them, and coping with the expected and unexpected. - Collected, analysed, managed and used information well to support all its activities, using secure electronic

	systems with security safeguards. - Invested in IT and had robust security systems which had been resilience tested. - Systems to ensure that its data sources were reliable and produced comprehensive performance dashboards to monitor performance over time. - Engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

TSDFT Board Well-led self-assessment against outstanding rating

Initial Annual Assessment: Nov-18

Status of progress towards closing Gaps: Jan-20

Torbay and South Devon NHS Foundation Trust

Appendix 2

W1	Leadership capacity & capability **Is there the leadership capacity and capability to deliver high-quality, sustainable care?**	Self-assessment **Green**
W1.1	Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?	
W1.2	Do leaders understand the challenges to quality and sustainability, and can they identify the actions needed to address them?	
W1.3	Are leaders visible and approachable?	
W1.4	Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?	
Characteristics of CQC rating: Outstanding		
There is compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There is a deeply embedded system of leadership development and succession planning, which aims to ensure that the leadership represents the diversity of the workforce. Comprehensive and successful leadership strategies are in place to ensure and sustain delivery and to develop the desired culture. Leaders have a deep understanding of issues, challenges and priorities in their service, and beyond.		

W1 Gaps to outstanding (Principal actions required to achieve outstanding)

Ref	Gap identified in Nov-18	Status in Jan-20:		Comments
1	Leadership resilience, both in capacity (including sufficient to give headspace for improvements and developments), and in capability (such as in succession planning and talent management).	SMD -System Medical Directors AMDs -Associate Medical Directors SDNPP -System Directors of Nursing and Professional Practice ADNPP -Associate Directors of Nursing and Professional Practice SLT -Senior Leadership Team Transition into the new Delivery model system is complete with directors across Torbay and South Devon in post. The SLT are now enabling the executive team to have head space for Internal and System Transformation Partnership (STP) focus on improvements and developments. Clinical leadership has been strengthened through the appointments of 2 System MDs and 5 AMDs. The 2 SDNPP and 4 Associates are in place. The appointment of the 5TH ADNPP is underway. The structure enables opportunity for Executive and Director personal development. The Trust are linking staff to the SW Aspiring Director and other Executive development courses such as Nye Bevan.	G	The Executive and Director Structure is now embedded. The Trust is now reviewing the operational management structure to ensure there is the right capacity and capability to deliver the Trust and STP strategy.

Ref	Gap identified in Nov-18	Status in Jan-20:		Comments
2	Lack of clarity on of whether there is a leadership strategy across the whole organisation	The ICO recognises the integral importance of creating the right conditions across the organisation to grow capacity and capability to deliver high-quality care and drive forward our integrated care model strategy and transformation programme. Our existing leadership strategy is under review and is being replaced by the development of our "Developing People strategy", with one of the underpinning pillars being leadership and succession planning. One of the key factors in creating capacity and capability across our organisation is through effective embedding of our new operational and clinical structure that ensures we organise services around people and pathways of care recognising the importance of integrating across settings of care and optimising the experience of personalised and accessible care that is joined up. This is a new structure and there is work to do to ensure we support this new way of working to flourish and operate effectively. Communication plan to ensure trust wide understanding of the leadership model are progressing and include VLOG, ICON page, drop in sessions Half day events in the Integrated Service Units (ISU).	A	In 2019 the Trust Board established a new 'People' sub-committee to drive forward the actions from the Interim People Plan and to ensure QI projects relating to the development of our people progress and deliver. Talent management strategy, succession plan and work to strengthen the Trust People Plan is underway through the People Committee.
3	Board identified the need to strengthen the focus on medical leadership and to complete implementation of medical leadership strategy. .	The Leadership strategy includes appointments to all leadership cross the Integrated Care Organisation (ICO). This includes medical staff positions as well as developing our 'new to post' consultants. Both programmes have been co-designed with doctors and their needs according to progress in their careers. Executive & System MDs have set up review of leadership skills and completed 360 (2019). With the AMDs new to post from April 2019 there is a plan to review after 9-12m in post. Locality Clinical Directors (LCDs) are reviewed annually and recent written reflections on achievements in the first 2.5 years of the post; one of the original LCDs has gone onto become an AMD (Moor to Sea). Succession planning to be developed and further work is required to fill cross ICO posts- e.g. Cancer Lead after excellent response to AMD posts. There is confidence that we have a pool of people to draw from. The new AMDs have been in post since April 2019 so to date they have not all completed a specific leadership 360 but they will be scheduled. All consultants are required to complete a clinical 360 appraisal in every 5 year revalidation cycle.	G	The impact of this process will be monitored by the People Committee.

Ref	Gap identified in Nov-18	Status in Jan-20:		Comments
4	We need to consider a cultural assessment (within medical leadership team rather than just clinical and other teams).	Matrix leadership is progressing well with greater understanding of the system issues e.g. consultant cover for medical outliers crosses 4 ISUs in terms of teams. The 360 from FMLM will strengthen further and will be implemented at the end of 2019. In last 12m the SCORE culture survey has been completed by three teams- maternity, pathology & ED. Methodology requires re-survey after action- maternity currently in progress.	G	The process is in place and progressing. Further work to capture the experience of senior medical leaders and respond to their learning will progress through 2020 and be monitored through the People Committee.
5	We need to have greater exposure to leaders below exec level. NEDs could / should attend cross-organisational meetings more to see leadership in action. Leaders below exec level should present regularly at Board committees.	Non-Executive Directors (NEDs) are members of key groups and Board committees across the Trust. Board development sessions with system directors and ISU leadership teams are scheduled regularly throughout the year.	G	The impact of this NED to Leaders and Managers will be monitored through the People Committee
6	There should be a greater focus on training for the middle management level.	Programmes are well established with good uptake of staff across the Trust for middle management training. Reviewed in last year to align with attitudes/behaviours required for systems, distributed leadership and self-organising.	G	
7	We should strengthen management action response to the annual staff survey and other feedback.	In publication of the Interim People Plan led to a review of the Board governance structure with recognition that the experience of our people is critical to the delivery of good and outstanding services. For this reason the People Committee was established in 2019. The Committee will increase the focus staff experience and how we improve. Throughout 208/19 there has been a focus on people with initiatives such as 'our Journey' designed to engage staff.	G	The development and monitoring of actions relating to the annual staff survey and other sources of feedback will be monitored through the people committee.
8	Review of leadership/ and management programmes in line with self-organised teams approach.	Some managers and staff remain uncertain what 'self-organised teams' are. This needs to be aligned to the Talent Management and Succession Planning approach.	A	Further review and refinement to be undertaken in next 12 months as the self-organising approach evolves along with the Trust People Plan development.

Ref	Gap identified in Nov-18	Status in Jan-20:		Comments
9	Develop plans that respond to the need for varied management training offer as managers can find it difficult to find time / opportunity to develop.	A range of leadership and management programmes are functioning well with good uptake. A number of key leaders in the Trust are undertaking a 2 year MBA with Exeter University. Coaching programme offered to all staff. Two day programme for ISU leads and System directors was held in July 2019.	G	The impact of this management training will be monitored through the people plan.
10	With a new CEO in place, some exec development sessions focussing on how the exec will work together and support and challenge each other will be required.	Executive development sessions have been held regularly throughout 2018/19. These provide the opportunity to informally discuss the critical issues and have helped to strengthen respect and trust. The Executive team also create opportunities to meet socially and have a social APP that contributes to building a strong team. New members have reported how welcoming and supportive the Executive team are.	G	
11	We need to message the positives	Using CEO weekly VLOG and Trust Talks to share good work and initiatives across the organisation. There is staff hero awards bi monthly and from these short listing for the annual award. Weekly Staff Bulletin utilised to share good news and positive messages. All staff e mails also share positive news as received. Bottom up spread of Learning from Excellence programme with acknowledgement of the day to day work which makes a difference for us all- currently 12 out of 35 specialist teams using this form of appreciative enquiry.	G	The impact of the increased focus on positive messaging will be monitored though the People Committee.

W2	Vision & Strategy **Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?**	Self-assessment	
		Green	**Amber**
W2.1	Is there a clear vision and a set of values, with quality and sustainability as the top priorities?		
W2.2	Is there a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care?		
W2.3	Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?		
W2.4	Do staff know and understand what the vision, values and strategy are, and their role in achieving them?		
W2.5	Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?		
W2.6	Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence to show this?		
Characteristics of CQC rating: Outstanding			
The strategy and supporting objectives and plans are stretching, challenging and innovative, while remaining achievable. Strategies and plans are fully aligned with plans in the wider health economy, and there is a demonstrated commitment to system-wide collaboration and leadership. There is a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans are consistently implemented, and have a positive impact on quality and sustainability of services.			

W2 Gaps to outstanding (Principal actions required to achieve outstanding)

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
1	Reporting from ISUs in new structure needs to be strengthened and include all elements of the Trust vision, values, strategy and objectives, using the revised business planning template to support reporting. Delivery of the new approach to join up strategy with front line operational team's annual business plans.	Five ISU now in place with revised governance structure and clear reporting lines. Early implementation and significant organisational change to align the performance, finance and quality metrics to the new delivery model have been established. The review of the reporting framework undertaken in 2019/20 included revision of committee and group terms of reference to reflect Trust strategy and objectives. Performance dashboards reflect regulator requirements but also Trust priorities. The	A	The revised reporting framework is bedding in. Effectiveness is being evaluated during Q4 through the Integrated Governance Group (IGG).
2	We need more input from local people at a formative stage of planning including the annual plans.	ISU have been well engaged to develop their locality plans and objectives formed as reported in the COO board report in May 2019. The positive relationship with Healthwatch continues and there are user groups across many ISU specialities. Users have been involved early in the development of the ED plans.	A	There is further work to do to build 'local conversations'. The Trust will be linking to the recently developed STP plan. Progress will be monitored through the IGG.

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
3	Consult with users on day-to-day / ongoing basis, not just when there are times of change. Make more of Government initiatives.	Working closer with Healthwatch and other groups such as young Devon. Active disability group and Treat me well group with partners. Talking points Close working with Rowcroft charity Active stakeholder groups in ISUs.	A	As above
4	Involve public in development of plans, in order to ensure we meet needs of population	Brixham Friends centre recently opened which reflects excellent partnership working across Trust and voluntary sector. Active stakeholder groups in ISUs.	A	As above
5	Suggested more communication to staff around government strategy for the NHS and the implications for the trust.	Sessions held to promote the Long Term Plan. Trust Talk and live streaming enable key national government messages to be shared. Engagement with external teams such as 4Eyes , GIRFT Mc Kinsey	G	Staff engagement in the wider national and STP agenda will be monitored through the People Committee
6	Recommended we increase staff awareness of the regulatory or centrally imposed areas of trust activity, i.e. the extent to which trust Execs have freedom to act / make decisions.	The CEO led Trust Talks is livestreamed to staff and focuses on the implications of national and STP strategies and how these link to the Trust strategy. The CEO VLOG has also communicated the STP priorities and how these link to Trust plans. Other forms of communication such as Trust Bulletin and ICON share wider NHS and STP plans. Regulator requirements are communicated using a range of communication strategies and Executive Freedom to Act or constraints are discussed in SLT and other IDU meetings.	G	Effective communication to staff about the impact of national and STP strategies will continue. The communication team are reviewing their approach to effective messaging in 2020.
7	Improve staff understanding of how ICO strategy is supported by underpinning strategies e.g. IT strategy	The number of IT systems that are fragile and lack of interoperability is impacting on front line staff experience. The fragility of the IMT system has been communicated to the SLT and senior clinicians through Trust Talks, the Clinical Management Group and other groups. They have been engaged in prioritising IMT priorities in 2019. There has been progress with EPMA implementation and implementing SystmOne and EMIS in two community teams linking with GP practices. Staff Engagement as part of Business Planning Process, Our Journey and development of local service plans has increased awareness. Critical IT failures in 2019 have affected staff and increased awareness.	A	The SLT have a good understanding of the fragility of our IMT system. There is recognition that this may not have been clearly communicated to ISU and front line teams. Communication will progress in 2020
8	Strategic threats to be included in BAF	The threats are clearly articulated and visual in the BAF and hot spot risk target. BAF regularly reviewed at Board, new process and heat map developed.	G	

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
9	Board need more exposure to the benefits of system working.	Executives should achieve more time to work system-wide with new delivery model in place. Exec Directors are fully engaged in system working and leading strategic pieces of work for the STP. NEDS are engaged directly in STP work	G	
10	Annual or twice yearly presentations from the operational leadership to the Board.	Attended Board in February 2019 Trust Board development day April 2019 Trust Board COO paper May 2019.	G	
11	Vision and strategy have been clarified – now finalising sharing that across trust	Delivery model and vision for clinical end to end care pathways in place and change in the model progressing. Our Journey visuals and tools used as a Vehicle.	G	

W3	Culture **Is there a culture of high-quality, sustainable care?**	Self-assessment **Amber/Green**
W3.1	Do staff feel supported, respected and valued?	
W3.2	Is the culture centred on the needs and experience of people who use services?	
W3.3	Do staff feel positive and proud to work in the organisation?	
W3.4	Is action taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority?	
W3.5	Does the culture encourage openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?	
W3.6	Are there mechanisms for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations?	
W3.7	Is there a strong emphasis on the safety and well-being of staff?	
W3.8	Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?	
W3.9	Are there cooperative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?	
Characteristics of CQC rating: Outstanding		
Leaders have an inspiring shared purpose, and strive to deliver and motivate staff to succeed. There are high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. There is a strong organisational commitment and effective action towards ensuring that there is equality and inclusion across the workforce. Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process. There is strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.		

W3 Gaps to outstanding (Principal actions required to achieve outstanding)

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
1	We need to communicate the vision to all staff	Vision communicated to staff and Our Journey communication packs utilised at team level. New Delivery model drop in sessions and visits to teams.	G	
2	Executives and & Directors need to have a higher profile	In 2019, Executives undertook a 'use of time' review to reduce the time spent in meetings and increase the time spent in clinical and service areas. Executives have undertaken regular visits on an ad hoc basis and have also under taken scheduled safety walkabouts. Some Executives have done back to the floor shifts. Executives have taken opportunities to use VLOGS and the Trust ICON pages to communicate with staff. The Executive engagement in STP activity increased in 2019 and this commitment was reviewed by the Board.	A	There is recognition that there is more to do to increase Executive visibility. A plan will be developed by the Executive Team for 2020.
3	Include information about investigations into medical staff in one of the medical HR Board reports.	Including all HR cases in the workforce and OD report to the People Committee including Medical.	G	
4	Consider cultural assessment in the medical leadership team as well as of clinical / other teams.	This has been established for the AMDs. The Workforce and Organisational Development (WOD) team built on ISU level inter-professional development in 2019. Opportunities with regional and national programmes have enabled us to carry out team cultural surveys (maternity, pathology & ED).	G	This work will continue in 2020 and the impact monitored through the People Committee
5	Following 2017 staff survey, responses highlighted some levels of concern with well-being, volumes of work and impact of challenging financial savings targets. This should be reflected in an increased focus on health and well-being programmes to support staff and development of self-organising teams approach.	Throughout 2018 / 19 there has been increased focus on staff wellbeing. HOPE programme for staff. Trust actively promote and have range of activities in relation to Health and Well Being. Well- being week supported each year with a range of activities In October 2019 we held the staff Olympics Health and well- being coaches EAP available to all staff.	G	The impact of this focus will be monitored thought the People Committee.
6	Continue to commit to actions against the staff survey. Data is there to listen to, we must listen to this otherwise will eat into staff goodwill and compassion	Staff survey action plan and review of progress at ISUs is part of performance reviews. Staff surveys are undertaken throughout the year and other forms of feedback such as Freedom to Speak Up guardians reports are also received by the Board. The actions resulting from the 2017 staff survey were reflected in improvement in the 2018 responses to some of the areas staff had highlighted.	A	The draft 2019 survey suggests there is more work to do with regard to appraisals, response to incidents and complaints.

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
7	Improve evidence regarding those with protected characteristics	EDI, EDS and WRES action plan implementation through supporting groups. The Trust WRES strategy is published on the Trust web site.	A	The national Interim People Plan provides guidance and direction with regard to improving engagement of those with protected characteristics. The Trust action plans will be monitored by the People Committee.
8	Address the well-being need, e.g. those highlighted from reviewing the staff sickness with the ISU leads. The constant pressure of working with high levels of occupancy deprives teams of development time.	There is clear reporting of long and short term staff sickness monthly at the ISU delivery groups, System Assurance and Transformation Group and the IGG. Staff sickness is included in the Board performance reports with regular updates on actions being taken to reduce sickness. Across the system many areas are working under significant pressure both within acute hospital and community services due to demand and complexity of care needs. Trust overall sickness is currently higher than planned with 'hot spots' of high sickness including the Emergency Department and Maternity. Action plans to improve staff wellbeing and reduce stress have been presented to the Board.	A	Staff report feeling under pressure and the highest causes of sickness continue to be stress and MSK injuries. Actions to address this are monitored through the People Committee and other Sub-committees.
9	Learn from launching of EFM own staff charter, mental health first aider and information boards displaying performance	OD team taking forward staff charter and MH first aider.	A	
10	Promote the evidence of good culture widely, identifying examples of outstanding practice amongst staff to help reinforce what outstanding looks like and develop self-belief e.g. compare with Salford. Informative versus celebratory trust news	Examples of outstanding practice are shared at a number of committees and groups. We also share positive stories at the Board, via ICON and in the staff Bulletin. The ISU teams provide examples of good and outstanding practice to the SLT Assurance and Transformation Group and these are shared with the Executive monthly at the IGG. The monthly Staff Heroes awards and annual Heroes ceremony provide opportunities to celebrate.	G	There is recognition that there is more to do but good progress has been made in 2019 to share good news.
11	Implement learning from development of the children's services alliances for longer-term planning	Due diligence and mobilisations successful. Positive events for all staff within CFHD service. Team level meetings taking place to appreciate what works well and where improvements need to take place. Audit review of TUPE process was satisfactory. The learning form this exercise will inform future acquisitions and partnerships.	G	

W4	Responsibilities, roles & accountability **Are there clear responsibilities, roles and systems of accountability to support good governance and management?**	Self-assessment **Green**
W4.1	Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?	
W4.2	Do all levels of governance and management function effectively and interact with each other appropriately?	
W4.3	Are staff at all levels clear about their roles and do they understand what they are accountable for, and to whom?	
W4.4	Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?	
Characteristics of CQC rating: Outstanding		
Governance arrangements are proactively reviewed and reflect best practice. A systematic approach is taken to working with other organisations to improve care outcomes.		

W4 Gaps to outstanding (Principal actions required to achieve outstanding)

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
1	Further work on role accountability across the organisation –including self-organised teams and what this means for all staff	All SLT roles include clear responsibility and accountability statements. The SLT triumvirates share responsibility and accountability for their standards and delivery of services but each role has specific portfolio responsibilities to ensure clarity. Organograms developed at ISU level for medical, AHP, nursing and ops where there have been changes in role accountability. The operational governance paper was presented to Board in December 2019. This clearly set out operational accountability. The Quality strategy sets out quality and safety accountability. Corporate governance enhanced to reflect the ISU delivery model. There has been an ICON short films from system directors. This work is in progress through clinically led leadership teams.	A	There is further work to do to increase team and staff understanding of self-organised teams.
2	There will need to be Internal audit – review of the new structures with change to new ISU structure, in due course.	The new SLT and ISU was established in April 2019. There has been ongoing review of effectiveness in terms of impact on quality, operations and finance performance throughout the year. The Risk Group and Audit Committee have monitored risk and performance throughout the year. The 2019 patient and staff surveys will also provide an indication of effectiveness. Whilst performance in a number of areas have been challenged in 2019, there is no evidence yet of a direct correlation between deterioration and the move to the Locality and ISU structure.	G	An internal audit of Locality and ISU effectiveness will be undertaken in 2020.
3	Survey of staff in new structure after period of time.	The 2018 national staff survey did not highlight material changes in staff reports about direct management, wellbeing and satisfaction.	A	There is recognition that more frequent surveys throughout the year would facilitate rapid cycle change. The WOD team are considering options.

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
4	Need to describe systematic approach of trust to initiatives within STP. Examples of good practice would be helpful – e.g. shared HR approaches, Mortality review, governance arrangements in networks, CYP.	Collaborative working with cardiology dermatology and neurology with neighbouring Trusts. The Trust MD has been appointed to the STP MD role. Trust Executives have led a number of STP priority workstreams throughout 2018/19. Trust Executives have informed the STP priorities. Examples of Trust led collaboration include: The Peninsular Clinical Services Strategy is developing Devon wide plans Children Family Health Devon Alliance.	G	Whilst some shared STP shared service plans are in development for HR and EFM these have not progressed in 2018/19. The Trust will continue to actively lead and participate in 2020.
5	New company secretary to initially review the governance processes.	The governance framework review was completed in 2019. This has increased clarity on how Trust business information, decisions and communications flow from point of care to chair and back. ToRs have been updated. Sub-groups have been reviewed to reduce the number where possible. The performance reporting of Quality, Operations and Finance are clearly set out.	G	Refinement and evaluation of effectiveness will continue in 2020. Monitoring of effectiveness with be through Board sub-committees and IGG.
6	Focus on route to Board for resources – IT, workforce, estates/equipment	The ToRs of operational groups have been reviewed. The performance reporting framework has been reviewed to ensure clear reporting of risks to IT, Workforce and EFM.	G	Refinement and effectiveness will continue in 2020. Monitoring of effectiveness with be through Board sub-committees and IGG.
7	Further assurance on new estates compliance structures.	New reporting format and governance structure in place. Gives comprehensive overview of estates compliance and activity reporting through Trust committees to Board Minutes of meetings document compliance issues. Estates compliance assurance paper going to July Trust Board.	G	
8	Clarify the role of the Governors and how the exec, the NEDs and the execs all work together in a way which allows support and challenge in the new structure	Governor membership has changed during 2018/19. The company secretary has led a reviewed the role and function of the Council of Governors (CoG) to ensure Governors are empowered. The CoG enables robust discussion and challenge of Trust NEDs and there is good evidence form the meetings in 2018/19 that Governors are holding to account.	G	

W5	Risks, issues & performance **Are there clear and effective processes for managing risks, issues and performance?**	Self-assessment **Green**
W5.1	Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?	
W5.2	Are there processes to manage current and future performance? Are these regularly reviewed and improved?	
W5.3	Is there a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken?	
W5.4	Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?	
W5.5	Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?	
W5.6	When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?	
Characteristics of CQC rating: Outstanding		
There is a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviews how they function and ensures that staff at all levels have the skills and knowledge to use those systems and processes effectively. Problems are identified and addressed quickly and openly.		

W5 Gaps to outstanding (Principal actions required to achieve outstanding)

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
1	Communicate governance and risk structures to staff	Reference Strategy section above	G	
2	Review of clinical audit processes	Clear process in place for audit and re-audit led by clinical audit effectiveness team and overseen in CAEG. Number of overdue policies have significantly reduced over 2018/19. Participation in Quality Account national audits good. Process for reviewing and implementing NICE guidance embedded. Process for initiating and completing local audits well established. Evidence of improvement reported to CAEG.	G	
3	Improve visibility and understanding of risk management and systems for all managerial roles.	As part of the Governance framework review, the function, membership role in assurance of the risk group has been refreshed. As part of the Locality and ISU restructure, every risk on the Datix system has been reviewed. The role of mangers in managing risk has been communicated as part of the restructure and risk monitoring and management is an integral part of ISU and governance meetings.	A	The role of self-organising teams in risk management will be strengthened in 2020. Effectiveness will be monitored through the Audit Committee.

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
4	Need to more clearly establish balance of empowerment of self-organised teams with driving accountability.	Need to develop a set of principles to underpin each ISU accountabilities and responsibilities as self- managed teams. To be taken forward in Systems	A	The role of self-organising teams and responsibility for service management will be strengthened in 2020. Effectiveness will be monitored through the Trust Committees.
5	Some reporting hampered by IT issues so upgraded patient information system needed	A range of IT systems fragile and starting to fail across the Trust intermittently. Approval for an update to the Aggreso finance system was approved in 2019. Investment in EPMA and community IT approved. Trust is linked to the Devon STP system solution.	R	Solutions to the IMT infrastucture reliant on external factors and funding.
6	Not always able to address staff concerns / risks due to lack of available capital e.g. lighting	Capital infrastructure risks remain with limited money to support requirements.	R	As above
7	Completion of action plans to enable meeting national standards	A number of action plans in place and closely monitored that align to national standards. Performance monitoring has been strengthened in 2019 as part of the ISU restructure and governance review.	G	
8	Establish assurance that systems are in place for new structure	The systems to provide assurance that systems and processes are in place to support the new delivery model are progressing well.	G	

W6	Information **Is appropriate and accurate information being effectively processed, challenged and acted on?**	Self-assessment Amber / Red
W6.1	Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?	
W6.2	Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and do they challenge it appropriately?	
W6.3	Are there clear and robust service performance measures, which are reported and monitored?	
W6.4	Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?	
W6.5	Are information technology systems used effectively to monitor and improve the quality of care?	
W6.6	Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?	
W6.7	Are there robust arrangements (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?	
Characteristics of CQC rating: Outstanding		
The service invests in innovative and best practice information systems and processes. The information used in reporting, performance management and delivering quality care is consistently found to be accurate, valid, reliable, timely and relevant. There is a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.		

W6 Gaps to outstanding (Principal actions required to achieve outstanding)

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
1	To continue to work towards and invest in a single Patient Management System	Progress with systemOne pilot and Emis Web in community linking community with primary care. An overall single patient management system is not in place at present.	A	Linking to Devon STP re a system solution.
2	To continue to work towards robust IT and EPR to support clinical care	IT systems across hospital site fragile in many areas. Mitigations are in place but there have been a number of failures in 2019.	R	
3	Revamp the trust's IT strategy so that information can move seamlessly through the organisation, e.g. through introduction of EPIC or other enterprise wide system.	Risk to effective clinical working; is the risk around the IT infrastructure and strategy adequately described and understood? The evidence for this ultimately comes through in the BAF. Along with Estates the IT infrastructure is shown on the recent "Assurance Radar" as a red issue, and this will drive the Board agenda along with the other areas that are being mitigated below the Board's acceptable risk threshold. We are commissioning an external review of our Health Informatics service that will consider the capacity and capability and infrastructure requirements to meet our clinical service strategy going forward. We are also working with partners across the STP in the development of our digital roadmap and in working with our regulator to make strategic decisions regarding a single Electronic Patient Record across hospital providers in Devon.	R	

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
4	We need investment in patient systems – interfaces improved to avoid gaps/overlaps & enable people to tell their story only once	Progress with systmOne pilot and Emis Web in two community teams linking community with primary care. Discharge hub read only access systmOne	R	As above
5	Address the high risk some systems now carry due to insufficient investment.	The risk is high and in some areas increasing with insufficient capital funding available.	R	As above
6	Full and regular performance reporting from all systems	ISU delivery model will support all parts of the organisation reporting performance. The performance team have aligned performance reports to the delivery model.	G	Performance reporting is under constant review to refine and increase accuracy and relevance. Effectiveness will be monitored through Board sub-groups and IGG.
7	We need to ensure all compliance reports have action plans	Each ISU is responsible for ensuring that compliance reports are acted on. A compliance officer was appointed in 2018 to ensure all service level audits and compliance reports had an associated action plan.	A	There is further work in 2020 to refine the collation process to ensure all compliance reports are collated and tracked.
8	There is an absolute wealth of information within the trust, which may hinder provision of clear, high quality data to the Board which may obscure critical issues.	Review of integrated performance reports has been well received by the Board and sub-committees. The performance reporting of the Locality and ISU teams through the Assurance and Transformation Group and the IGG is comprehensive. Variances are identified and there is evidence that these are reflected in risks and the BAF.	G	Performance reporting is under constant review to refine and increase accuracy and relevance. Effectiveness will be monitored through Board sub-groups and IGG.
9	To review and ensure accurate information is retrievable and available in a timely way that is useful to staff, to support improvement and decision making.	The availability and relevance of information to Locality and ISU Teams has improved. The information available to individual clinicians is variable and does not enable decision making. Within the limits of current IT systems we need to explore how we can improve clinician level data.	A	There will be a focus on clinician level data in 2020

W7	Engagement **Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?**	Self-assessment **Amber/Green**
W7.1	Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?	
W7.2	Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?	
W7.3	Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?	
W7.4	Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?	
W7.5	Is there transparency and openness with all stakeholders about performance?	

Characteristics of CQC rating: Outstanding

There are consistently high levels of constructive engagement with staff and people who use services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders is welcomed and seen as a vital way of holding services to account.
Services are developed with the full participation of those who use them, staff and external partners as equal partners. Innovative approaches are used to gather feedback from people who use services and the public, including people in different equality groups, and there is a demonstrated commitment to acting on feedback.
The service takes a leadership role in its health system to identify and proactively address challenges and meet the needs of the population.

W7 Gaps to outstanding (Principal actions required to achieve outstanding)

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
1	Public engagement on service re-design. Need to challenge services to utilise patient feedback and engagement in planning at all levels and stages.	LD Treat me well group .SPOT and space work. Health watch Carers strategy Voluntary sector engagement strategy. Community conversations re LTP are in the planning. Carers triangle of care strategy	A	
2	Engagement with care model 2.	Our Journey Materials and as above		
3	Develop more creative two-way communications with staff and local population to demonstrate innovative care solutions arising from new ways of working.	Communication plan and ISU half days across the Trust Just Ask Our journey internally Community engagement as in 1	A	
4	Continue with real time user feedback across all areas of the trust – will need investment.	Real time patient Feedback group have implemented the Northumbria project in 2019 in enhance existing methods of real time feedback. Actions are underway to respond to the learning. The Working With Us panel of volunteers continue their work on real time feedback. This information is reported at the Quality Improvement Group.	G	

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
5	Seek more user feedback from all services, e.g. End of Life	EOL feedback questionnaire community and inpatient FFT National surveys eg Maternity survey, Inpatient survey, UEC, CYP. Recent Healthwatch review of young people's experience of the community	A	

W8	Learning, continuous improvement & innovation **Are there robust systems and processes for learning, continuous improvement and innovation?**	Self-assessment A / R
W8.1	In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?	
W8.2	Are there standardised improvement tools and methods, and do staff have the skills to use them?	
W8.3	How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the servicer? Is learning shared effectively and used to make improvements?	
W8.4	Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?	
W8.5	Are there systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?	
Characteristics of CQC rating: Outstanding		
There is a fully embedded and systematic approach to improvement, which makes consistent use of a recognised improvement methodology. Improvement is seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills are available and used across the organisation, and staff are empowered to lead and deliver change. Safe innovation is celebrated. There is a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There is a strong record of sharing work locally, nationally and internationally.		

W8 Gaps to outstanding (Principal actions required to achieve outstanding)

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
1	Description of Quality Improvement approach in new structure, to include strengthening spread of skills and access to QI through new structure implementation	QI team provide support to staff teams and services to undertake improvement projects. Planned general efficiencies and the transformation programme depend on the capacity of key enablers within the system to deliver improvement and innovation. We have a small but highly trained and dedicated expertise for Quality Improvement and we are developing a new approach to QI to enable the spread of expertise that is necessary to support the scale and pace of our clinical serves strategy and wider transformation. This is work that is underway and links closely to the development of our new system leadership teams and self-organising Integrated Service Units.	A	
2	Description of links to other providers – STP Academy plans and our involvement as it develops.	Work with Plymouth University, South Devon College , AHSN(SW).	A	
3	Establish a forum/virtual for sharing our improvement work	We have a site within our intranet site for sharing QI and set up a twitter account.	A	
4	Protected time and space for reflection and development.	Coaching access available to all staff. Promoted and encouraged through all leadership development programmes, the importance and necessity.	A	

Ref	Gap identified in Nov-18	Status in Jan-20	RAG rating	Comments
6	Managers to attend Continuous Improvement Training	Multiple courses run for individuals and teams throughout the year. New opportunities this year inc: Outpatient Transformation Programme (in house) Flow coaching – Methodology from Sheffield University Hospitals with RD&E & DPT hosting locally to train teams in Devon. Paediatrician and Paed General Manager attending, also cardiology team joined. All 5 intermediate care teams worked on QI plan for 2019-20 – work in progress Trainees (medical & nursing) have QI Programme set up for first year with ICO.	A	
7	Embed continuous improvement into Divisions	Each System has QI expertise within System Directors and working jointly together this leadership focus will result in QI progress e.g. Torbay leading on outpatient transformation with clear aims being set (June 2019).	A	
8	ICO care model and need to identify CIP savings	Programme of CIP projects and transformation projects active in SMART sheet. Fortnightly PIMS meetings in place to drive cost improvement.	A	
9	Establish evidence capture of current ongoing work by clinical teams	QI department can describe all areas of work within ICO – smaller projects by individuals or teams encouraged to register through clinical effectiveness. And plan to bring together the various different teams working in this space over the next 12 months so as to concentrate resources and personnel. June- presentations by F1 and QI Trust Fellows to the Board on their projects in the last academic year.	A	
10	Protected time needed, especially considering seasonal pressures	Protected time is challenging and teams and services have great ideas for QI but little head room to maximise opportunity.	R	We need to consider how we enable staff to participate fully in QI and the full range of training opportunities.
11	Consider how to capture and quantify externally accessed training and development programmes/events to more accurately reflect the investment into training and development	The Trust invests in education and training and for staff. Some of this collated centrally by the Education and Training team and on ESR but the majority of non-mandatory training data is held locally.	R	The Education and Training team are working to develop a means of collating staff CPD.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Quality Assurance Committee Terms of Reference			Meeting date: 5th February 2020
Report appendix	N/A		
Report sponsor	Chair, Quality Assurance Committee		
Report author	Company Secretary		
Report provenance	Reviewed and agreed by the Quality Assurance Committee on 22nd January 2020		
Purpose of the report and key issues for consideration/decision	It is deemed good practice to review Terms of Reference on an annual basis to ensure they remain appropriate and reflect current practice. The Quality Assurance Committee have undertaken a review of the Terms of Reference and were agreed at the committee meeting held on 22 January 2020.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board of Directors is asked to approve the Quality Assurance Committee Terms of Reference.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience		**Valuing our workforce**	
Improved wellbeing through partnership		**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	n/a	**Risk score**	n/a
Risk Register	n/a	**Risk score**	n/a

External standards affected by this report and associated risks

Care Quality Commission	**X**	**Terms of Authorisation**	
NHS Improvement	**X**	**Legislation**	**X**
NHS England		**National policy/guidance**	**X**

Torbay and South Devon
NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

TERMS OF REFERENCE

Version:	**1.0**
Approved by:	**Quality Assurance Committee**
Date approved:	**22 January 2020**
Approved by:	**Board of Directors**
Date approved:	**5 February 2020**
Date issued:	**6 February 2020**
Review date:	**January 2021**

TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

QUALITY ASSURANCE COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1 The Committee is constituted as a Standing Committee of the Trust Board ('Board'). Its constitution and terms of reference are subject to amendment by the Board.

1.2 The Committee will adhere to, and be cognisant of, the Trust values at all times.

2. Authority

2.1 The Quality Assurance Committee ('the Committee') is formally established as a sub-committee of the Board of Directors of Torbay and South Devon NHS Foundation Trust.

2.2 The Committee derives its power from the Board and has no executive powers, other than those specifically delegated in these terms of reference.

3. Purpose

3.1 The purpose of the Committee is to:

3.1.1 provide assurance to the Board that there is continuous and measurable improvement in the quality of services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care.

3.1.2 ensure that the risks associated with the quality of the delivery of patient care are identified and managed appropriately.

3.2 The Committee is responsible for:

3.2.1 reviewing proposed quality improvement priorities and monitoring performance and improvement against the Trust's quality priorities and the implementation of the Quality Account.

3.2.2 seeking assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified.

3.2.3 the ongoing monitoring of compliance with national quality standards and local requirements.

4. Powers

4.1 The Committee is authorised by the Board to investigate any activity within its terms of reference.

4.2 The Committee is accountable to the Board and any changes to these terms of reference must be approved by the Board of Directors.

4.3 The Committee may set up subgroups aligned to key areas of its activity as it deems appropriate.

4.4 The committee will promote local level responsibility and accountability.

4.5 The Committee is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

4.6 The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

4.7 The Committee is authorised by the Board to obtain outside legal or other specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board.

4.8 The Committee reserves the right to hold meetings in private ie comprising of Committee members only.

5. Duties and Responsibilities

The duties and responsibilities of the Committee, given below, cover quality improvement, governance and risk, quality and safety reporting and audit and assurance.

<u>Quality and Improvement</u>

5.1 Monitor and review the quality of clinical and social care services provided by the Trust. This will include review of:

5.1.1 the systems in place to ensure the delivery of safe, high quality, person-centred care

5.1.2 quality indicators flagged as ‘of concern’ through escalation reporting or as requested by the Trust Board

5.1.3 an action log evidencing progress toward completion

5.1.4 progress toward delivery of the Trust’s clinical strategy

5.2 Review variances against quality and operational performance standards.

5.3 Review proposed quality improvement targets as set out in the Annual Plan and by the Regulator. Provide assurance to the Board that improvement targets are based on achievable action plans and quality performance issues are acted upon.

5.4 Ensure there is a robust Quality and Equality Impact Assessment process to mitigate any adverse impact of service changes or reconfiguration.

5.5 Review the Trust's compliance with the Care Quality Commission essential standards of quality and safety and seek assurance regarding process with action plans in response to quality concerns identified from inspection findings, warning notices and compliance actions.

5.6 Receive, through the reporting schedule, assurance of high quality care provision and compliance with national and local guidelines, standards and requirements.

5.7 Oversee the development of the Quality Account regarding accuracy of data and compliance with timescales for publication and review progress against these.

5.8 Establish, develop and maintain systems and processes for the regular evaluation and monitoring of compliance against any relevant internal and external assessment, standards or criteria.

5.9 Ensure the Trust learns from national and local reviews and inspections and implements all necessary recommendations to improve the quality of care.

<u>Governance and Risk</u>

5.10 Oversee how all quality risks are managed across the Trust and that appropriate review and assurance mechanisms are in place, receiving and reviewing quality risks on the corporate risk register and Board Assurance Framework.

5.11 Promote an open culture in which incident and risk reporting is encouraged and supported as part of the delivery of safe and effective healthcare.

5.12 Seek assurance on the process for reviewing and reporting complaints, adverse events and serious incidents and sharing the learning from these.

5.13 Seek assurance against compliance with national clinical standards including NICE guidelines/guidance and any rationale for non or partial compliance.

5.14 Oversee any procedural, policy or strategy document which fall within the remit of the Committee are appropriately written, ratified and monitored for compliance in accordance with any key national standards and best practice.

5.15 Establish an annual work plan which the Committee will review at each meeting.

5.16 Produce an annual report against delivery of the terms of reference of the committee.

5.17 Undertake an annual review of the Committee's effectiveness

Quality and Safety Reporting

5.18 Receive reports from each of the Committee's sub-groups.

5.19 Receive and review submissions to national bodies and make recommendations for sign-off by the Trust Board.

5.20 Receive annual assurance reports in relation to (but not limited to) infection control and safeguarding.

Audit and Assurance

5.21 Receive and review the findings of quality related Internal Audit reports and seek assurance that recommendations are implemented in a timely and effective way.

5.22 Approve and oversee delivery of the Clinical Audit Plan and provide assurance to the Audit Committee of delivery.

5.23 Receive by exception information of national clinical audits where the Trust is identified as an outlier or a potential outlier.

5.24 Receive reports from invited service reviews and external visits (as appropriate) and seek assurance regarding delivery of actions.

5.25 Receive reports on significant concerns or adverse findings highlighted by external bodies in relation to quality and safety and the actions being taken.

6 Membership

6.1 The Committee shall consist of the following members:

- Non- Executive Director
- Non-Executive Director
- Non-Executive Director
- Medical Director
- Chief Nurse
- Chief Operating Officer
- Director of Workforce and Organisational Development

6.2 One of the Non-Executive Directors shall act as Committee Chair. In their absence, one of the other Non-Executive Directors present shall be nominated and appointed as acting Chair for the meeting.

6.3 The following shall be invited to attend all meetings of the Committee:

- Governor observer (see 6.4 for appointment process)
- CCG quality lead representative

6.4 The process for selecting the Governor observer is a matter for the Chair of the Council of Governors and Governors. In the event that the nominated Governor observer is unable to attend a meeting, the Committee Chair will allow a substitute Governor to attend.

6.5 Other members/attendees may be co-opted or requested to attend as considered appropriate.

7 Attendance

7.1 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

8. Quorum

8.1 The quorum necessary for the transaction of business shall be 4 members, of which two Non-Executive Directors and either the Medical Director or Chief Nurse must be present.

8.2 A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

8.3 Deputies will not count towards the quorum.

9. Administration

9.1 The Committee shall be supported by the Company Secretary or their nominee, whose duties in this respect will include:

9.1.1 in consultation with the Committee Chair and Chief Nurse develop and maintain the reporting schedule to the Committee.

9.1.2 collation of papers and drafting of the agenda for agreement by the Chair of the Committee.

9.1.3 taking the minutes and keeping a record of matters arising and issues to be carried forward.

9.1.4 advising the Committee of scheduled agenda items.

9.1.5 agreeing the action schedule with the Chair and ensuring circulation.

9.1.6 maintaining a record of attendance.

10. Meetings

10.1 Meetings will be held on the following basis:

10.1.1 meetings will be held bi-monthly (every two months).

10.1.2 meeting duration will be no longer than 2.5 hours.

10.1.3 items for the agenda should be sent to the Committee Secretary a minimum of 7 days prior to the meeting. Urgent items may be raised under 'any other business'.

10.1.4 the agenda with be issued by email to the Committee members and attendees, one week prior to the meeting date, together with the action schedule and other associated papers.

10.1.5 an action schedule will be circulated to members following each meeting and must be duly completed and returned to the Committee Secretary for circulation with the following meeting's agenda and associated papers.

11. Reporting

11.1 The Committee will provide a report to the Trust Board of Directors in support of its work on promoting good management and assurance processes. The report shall include matters requiring escalation and key risks (as applicable).

11.2 The Committee will receive reports as per the meeting work plan.

11.3 A briefing from those Groups reporting up to the Committee detailing items for escalation and key risks (as applicable) will be received by the Committee along with exception reports as agreed.

12. Review

12.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

12.2 The Committee's Terms of Reference shall be reviewed on an annual basis and approved by the Board of Directors.

13. Monitoring effectiveness

13.1 In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Board, the Chair will ensure that once a year a review of the following is undertaken and reported

to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled; and
- An annual self-assessment on the effectiveness of the Committee is undertaken.

Torbay and South Devon NHS
NHS Foundation Trust

Report of the People Committee Chair to the Board of Directors

Meeting date:	9th December 2019
Report by:	Vikki Matthews
This report is for: *(please select one box)*	Information ☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☐ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☐ 4: Well led ☐
Public or Private *(please select one box)* ***[If the Board requires information on sensitive or confidential matters please mark 'Private']***	Public ☒ or Private ☐

Key issues to highlight to the Board:

- **Terms of Reference & membership** – the Committee acknowledges the broad nature of the people agenda and has worked to ensure that the Terms of Reference are sufficiently focused so that we can offer robust assurance on people related matters affecting delivery of the Trust's 4 strategic objectives.

- **Trust's People Plan** – a framework for the development of the Trust's People Plan was shared. Assurance was received that the plan will focus both on short term improvements to the staff experience and longer term strategic change such as the workforce redesign and tackling long term recruitment issues. This was reinforced through the Acting Medical Director's update on the medical workforce job planning and the importance of a multi-disciplinary team approach.

- **People related dashboard** – a dashboard of useful data was reviewed. The Committee asked that the data be aligned to the expected outcomes from the Trust's revised People Plan. 2 specific call outs:
  - The Committee has asked for assurance that headcount and salary data will be aligned going forward and assurance was received that work is in hand and that progress will be reported back through future Committee meetings.
  - Of note, and of concern, was the increasing sickness absence figures which as at October 2019 stood at 4.2%, an increase from 3.4% in May 2019. The fact that this is a national picture provides context but not assurance and therefore further assurance is sought on this point which will come through the Trust's developing People Plan.

- **Recruitment** – concerns were expressed about the increasing spend on agency which was £4m over budget at the time of the meeting. Assurance was received that the seriousness of this issue is recognised and that the team has developed a rolling programme of improvements to the recruitment service plan. A new group called the Recruitment Planning and Redesign Group has been created, the Terms of Reference of which the Committee will review at the next meeting.

- **Emergency Department (ED)** – an item was raised by DWOD in relation to the ED department and the issues that have been raised through the Freedom to Speak up Guardians. A full report on the situation and the proposed solution will be brought to the next meeting but in the interim,

the Committee were assured that a range of interventions and are being used to get to the heart of the matter.
Key decision(s)/recommendations made by the Committee:

Torbay and South Devon NHS
NHS Foundation Trust

Report of Finance, Performance and Digital Committee Chair to TSDFT Board of Directors

Meeting date:	17th December 2019
Report by + date:	Chris Balch, 13 January 2020
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒or Private ☐

Key issues to highlight to the Board (Month 8, November 2019):

1. For assurance the Committee reviewed the Month 9 Financial Performance, which is a £8.73m deficit, which is £1.94m adverse against the plan of £6.80m. This is as expected given the change in control total notified by the Trust at Month 6. For months 1 to 6 the Trust has assumed it will earn the Provider sustainability Fund (PSF) and Marginal Rate Emergency Rule (MRET) funding of £3.51m (as the Trust delivered the control total in that period). From Month 7 onwards, only MRET income is assumed due to projected non delivery of control total. The Trust has assumed that it will not implement the revised RICS guidance for MEA on the grounds of materiality which has meant there is an additional benefit since month 7. This remains to be confirmed.

2. The Trust has delivered £6.7m of a £9.0m CIP target for month 8. Of the full year CIP target of £20m CIP, some £9.8m of savings have been identified resulting in a £10.2m gap.

3. Capital expenditure at Month 8 was £6.2m which is a £3.2m underspend against a budget of £9.4m Full year capital spend of £18.2m is forecast which would result in a £0.9m underspend. An Emergency Loan application has been made for expenditure on bringing the two Theatres back into use. This is required to address the Trust's projected cash position at the year end.

4. For assurance the Committee reviewed the Month 8 Performance Standards which remain challenged and are subject to continuing management action to deliver improvements. Reductions in the number of 52-week waits were noted as was progress in reducing diagnostic delays which are expected to help deliver improvement in the 62-day cancer treatment standard. ED waits remain a key priority for action.

5. An update was provided on the Action Plan which has been developed in response to the findings of KPMG review. This included a deep dive into the use of Agency Nursing which provided clear recommendations for continuing to manage down Bank and Agency expenditure. The report highlighted that ED has by far the largest use of Agency staff.

6. A presentation on the Trust's approach to business planning for 2020/21 was received and discussed.

7. The Risk Register was reviewed and items requiring updating and review at subsequent meetings identified.

8. Reports were received and noted on:
    - Torbay Pharmaceuticals financial performance to November 2019
    - The work of the Capital, Infrastructure and Environment Group, including the EFM Compliance and Performance Report
    - The work of the IM&T Group
    - SDH Innovations Partnership Annual Report and Accounts

Key Decision(s)/Recommendations Made:

1. To note the above.
2. The Committee approved the month 8 self-certification form submitted to NHSI.
3. The Committee received and approved the business case for the implementation of the Tableau Business Intelligence tool which will provide real time and tailored management information to enable faster and better-informed decision making within the Trust.
4. The Committee received and approved proposals for the Trust to take direct responsibility for the commissioning of domiciliary care in Torbay following the ending of the Mears contract and introducing a new hourly fee for services provided by independent providers. The proposal is intended to stabilise and develop the market for domiciliary care in the Bay and limit the payment of costly 'spot' rates. It was agreed that further research would be beneficial to establish the benefits flowing from the enhanced delivery of domiciliary care into the wider system.

Name: Chris Balch (Committee Chair)

Torbay and South Devon NHS
NHS Foundation Trust

Report of Finance, Performance and Digital Committee Chair to TSDFT Board of Directors

Meeting date:	28th January 2020
Report by + date:	Chris Balch, 29th January 2020
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒or Private ☐

Key issues to highlight to the Board (Month 9, December 2019):

1. For assurance the Committee reviewed the Month 9 Financial Performance, which is a £10.14m deficit, which is £3.27m adverse against the plan of £6.87m. This is as expected given the change in control total notified by the Trust at Month 6. For months 1 to 6 the Trust has assumed it will earn the PSF and MRET funding of £3.51m (as the Trust delivered the control total in that period). From M7 onwards, only MRET income is assumed due to projected non delivery of control total. It should be noted that the agreed recovery plan assumes that the Trust does not The Trust is assuming that it will not implement the revised RICS guidance for MEA on the grounds of materiality which has meant there is an additional benefit since month 7. This remains to be confirmed and is the subject of discussion with the external auditors and presents a £1.8m risk to the forecast outturn.

2. The Trust has delivered £8.2m of a £11.1m CIP target for month 9. Of the full year CIP target of £20m CIP, some £10.3m of savings have been identified resulting in a £9.7m gap. It was reported that only £2.6m of the savings achieved to date are recurrent highlighting the scale of the financial challenge for 20/21.

3. Capital expenditure at Month 9 was £7.1m which is a £5.6m underspend against a budget of £12.81m Full year capital spend of £18.7m is forecast which would result in a £0.87m underspend. An Emergency Loan for expenditure on bringing the two Theatres back into use has been approved which will support the Trust's projected cash position at the year end.

4. The Committee approved the month 9 self-certification form M8 submitted to NHSI.

5. The Committee received and approved a business case for the establishment of a Surgical Assessment Unit using Winter Funding which has been made available to the Trust to assisting in improving flow and performance through ED. It was emphasised that the associated non-recurrent revenue funding should not be used to incur incremental expenditure of a recurrent nature, and that a sustainable and affordable solution for SAU had to be found.

6. Subject securing the necessary assurances from the Trust's partners the Committee approved proposals for a Windows 10 and hardware replacement programme for Children and Family Health Devon.

7. The Committee received and approved proposals for the annual renewal of the Trust's insurance policies involving minor adjustments to the scope of cover sought.

8. For assurance the Committee reviewed the Month 9 Performance Standards which remain challenged and are subject to continuing management action to deliver improvements. Reductions in diagnostic delays is leading to improvements in the 62-day cancer treatment standard. ED waits remain a key priority for action.

9. A PIR on TP's move to Wilkins Drive was received from which valuable learning points were highlighted. The schedule of future PIRs was tabled as the basis for further reports which will be reviewed by the Committee.

10. A report was received on progress in assembling the Trust's budget for 2020/21. The challenge of closing the gap between STP figures (£37.5m deficit) and the Trust's bottom-up budgeting (£44.5m deficit) was highlighted. Intensive discussions are currently underway with the ISUs to achieve a deliverable, safe and acceptable budget.

11. The Committee received a presentation on the external review of the Trust's HIS Service from Sirius. This highlighted some important conclusions regarding the resourcing and governance of the HIS function and the need for a more strategic approach.

12. The Committee reviewed the Risk Register and requested that work be undertaken to ensure that this is fully up to date.

13. Reports were received and noted on:
    - Torbay Pharmaceuticals financial performance to November 2019
    - The work of the IM&T Group

Key Decision(s)/Recommendations Made:

1. To note the above.

Name: Chris Balch (Committee Chair)

Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Safer Staffing and Nursing Work Programme Monthly Update			Meeting date: 5th February 2020
Report appendix	None		
Report sponsor	Chief Nurse and Deputy Chief Executive		
Report author	System Director of Nursing and Professional Practice – South Devon		
Report provenance	Executive Directors Quality Improvement Group		
Purpose of the report and key issues for consideration/decision	This is the monthly safer staffing report as required by the Chief Nursing Officer NHSE.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	Note the contents		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership		**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework		**Risk score**	
Risk Register	x	**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	X	**Terms of Authorisation**	
NHS Improvement	X	**Legislation**	
NHS England	X	**National policy/guidance**	X

Articulate any risks and implications arising from this report.

Report title: Safer Staffing and Nursing Work Programme Monthly Update		Meeting date: 5th February 2020
Report sponsor	Chief Nurse and Deputy Chief Executive	
Report author	System Director of Nursing and Professional Practice – South Devon	

1. Introduction

The purpose of this report is to provide information and assurance monthly to the Board regarding the Nursing and Midwifery Safer Staffing levels. The information supplied and triangulated is for December 2019.

2. Discussion

2.1 Model Hospital Data

On a monthly basis the number of planned nursing hours (based upon the agreed baseline safe daily staffing numbers for each ward) and actual nursing hours (the total number of nursing hours used each day) for each inpatient ward area is submitted to the national dataset. This month sees the changes nationally that now includes allied health care professionals and qualified nursing associates if they provide direct patient care as part of ward establishments, at present Torbay and South Devon NHS Foundation Trust does not include allied health care professionals and qualified nursing associates.

The model hospital dashboard was updated in October 2019 to show the national median data which is 8.0 Total: i.e 4.7 RN & 3.2 HCA.

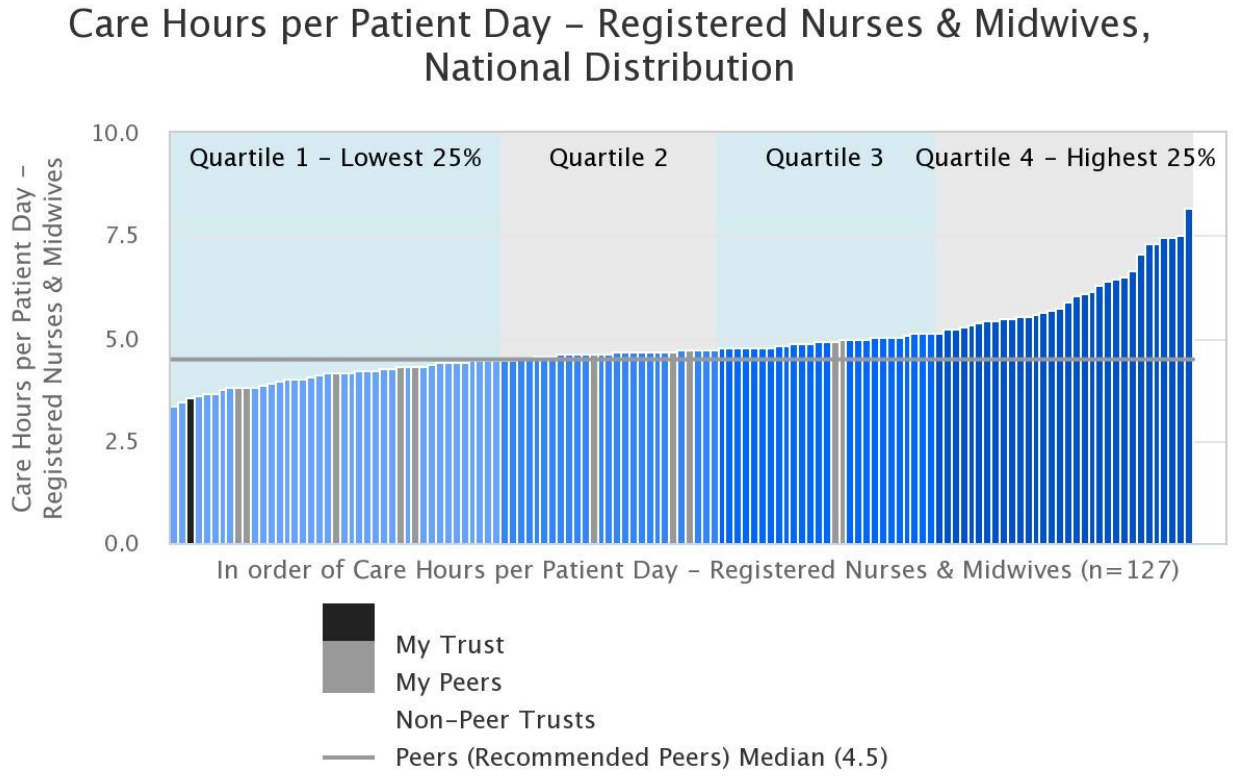
The Table below shows the Trust CHPPD position for December 2019 alongside national median data and peer regional data. The Trust is now below the national and peer RN range at 3.54 and significantly above the national and peer for HCAs at 4.02.

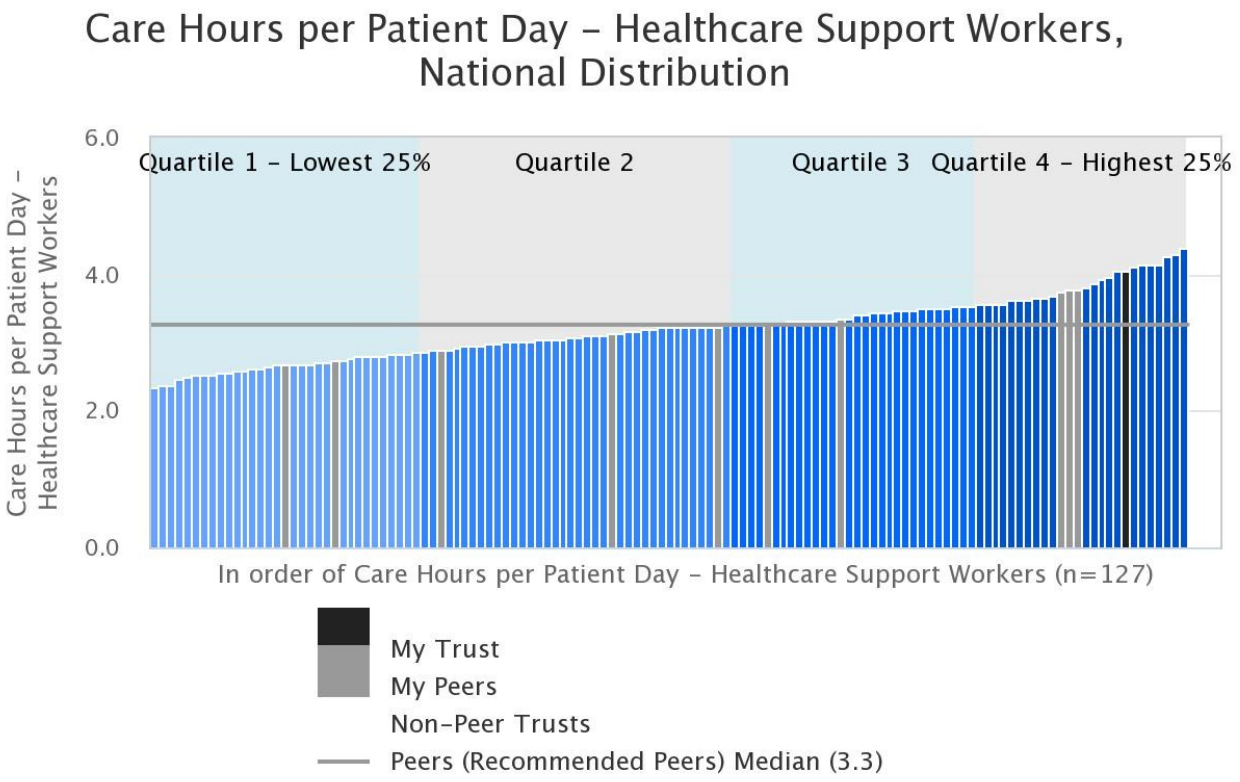
For December our position in the Trust has demonstrated that our overall comparison total CHPPD is 7.56 against a national median of 8.0 (National data is October 19). The RN CHPPD position demonstrates a slight decrease in comparison to last month 3.64 for Nov in comparison to 3.54 for December; we still have further improvement within our recruitment to RN positions to be comparable against our peers and national data.

HCA CHPPD position has decreased from November (4.19 to Dec 4.02), remaining an outlier in relation to our peers and national position (see below graphs from model hospital), we know that this is due to enhanced supervision and backfill for unfilled RN shifts where it is deemed safe, we are working on recruitment and retention solutions to address this.

					Model Hospital		
	TSDFT December 2019	TSDFT November 2019	TSDFT Oct 2019	TSDFT Sept 2019	TSDFT Oct 2019	Peer – Region Oct 2019	National Median Oct 2019
Total CHPPD	7.56	7.83	7.74	8.17	7.6	7.8	8.0
RN/ RM CHPPD	3.54	3.64	3.67	3.92	3.4	4.5	4.7
HCA / MCA CHPPD	4.02	4.19	4.07	4.25	4.1	3.3	3.2

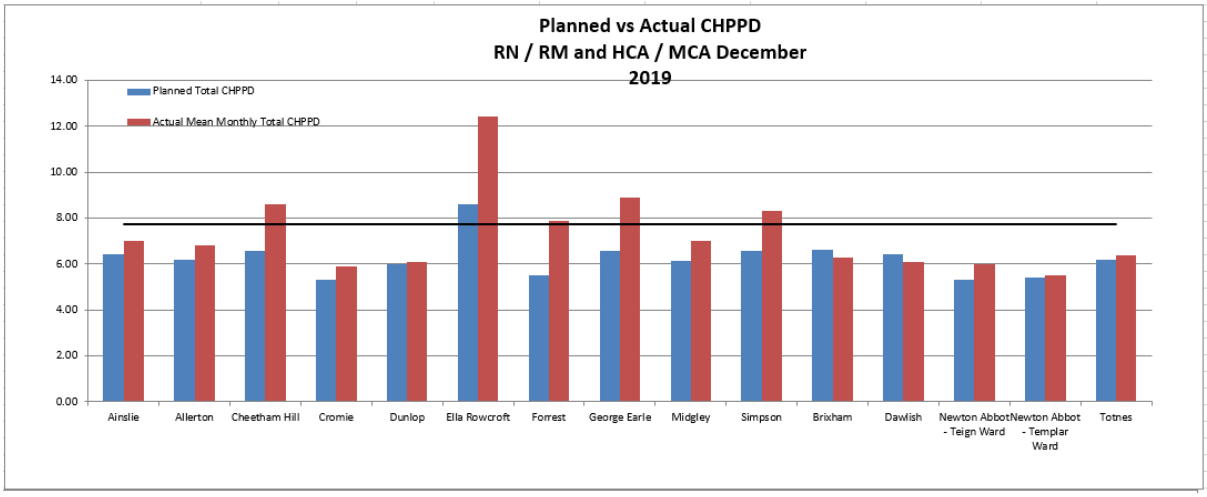
Model Hospital data – October 2019 data



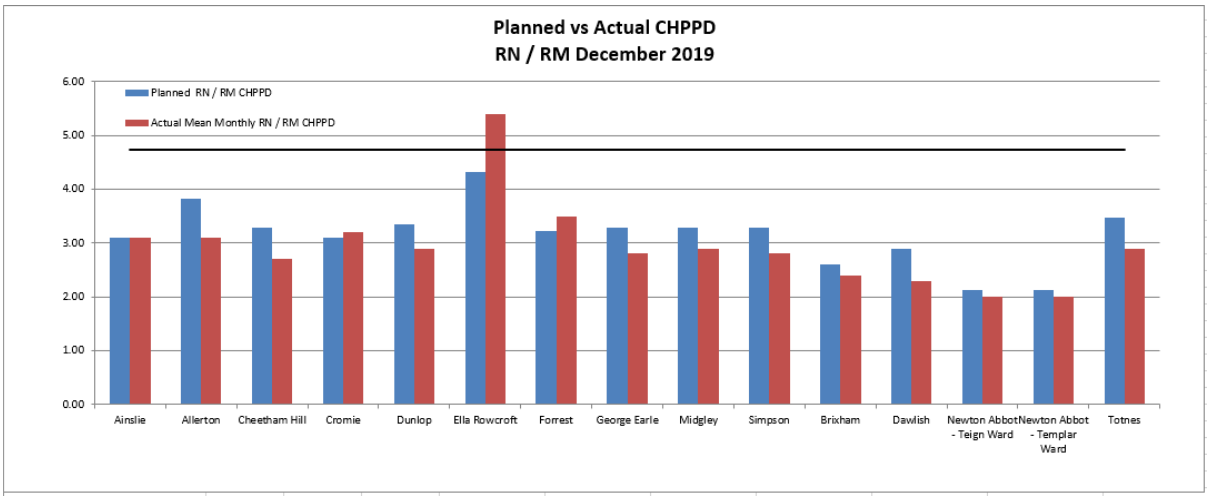


The graphs below illustrates the CHPPD data distributed by ward area, shown as a total of all nursing staff, and then separately for RNs and HCAs. The model hospital data should be viewed with caution as it relies on accurate input from providers and the accuracy is still being worked on.

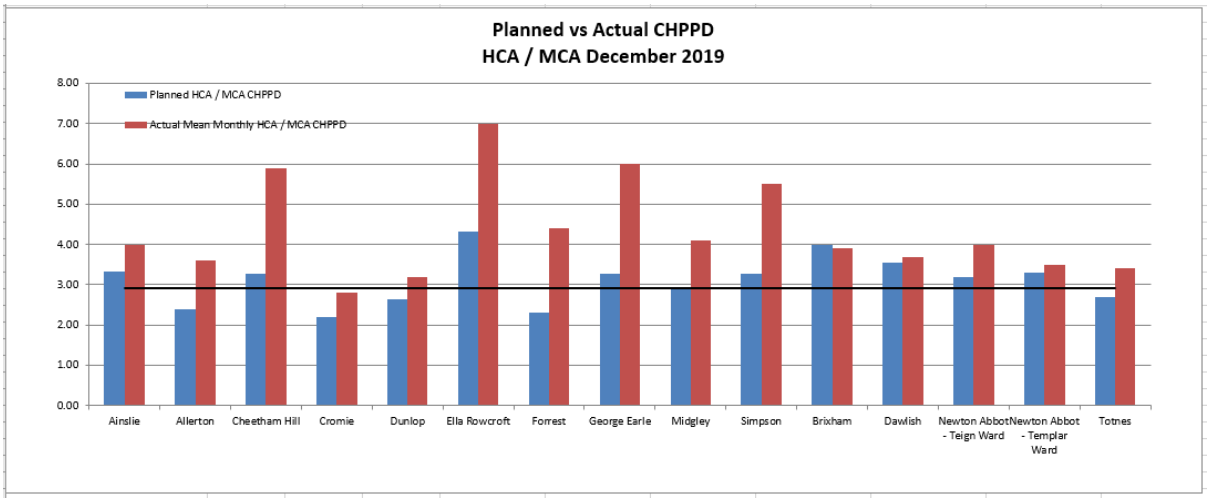
The graphs below reflect a largely stable picture over the previous months. As before, the higher than planned use of HCAs is predominantly due to the additional requirements of patients requiring supportive observation; wards across the Trust continue to identify patients who require additional observational support, for example, to maintain safety due to confusion, behavioural difficulties and falls risks. Where deemed appropriate and possible the wards cohort patients who require supportive observations. When there is shortfall in RN availability on a short term basis but is in accordance with the Carter safe staffing levels, if it is deemed appropriate additional HCAs are sourced. In this scenario the HCA does not replace the role of the RN, however their input is supportive in maintaining oversight of patient areas.



The graph above show that there are a number of areas where the actual RNs are above the current planned RN numbers; this would be in relation to increased escalation areas when the organisation has been in OPEL3 and OPEL 4 and the start of the winter plans. When reviewing the last graph below our usage of HCA's has been to assist with the patient ratio when utilising escalation areas.



The graph above show that Ella Rowcroft and Forest actual RNs are above the current planned RN numbers; this would be in relation to increased escalation during OPEL 3/4.



A review of establishments has been completed and budgeted establishments are now reflected within Healthroster. Safecare has provided Trustwide visibility of safe staffing across the organisation alongside real time acuity and dependency of patients within inpatient ward areas. As with any new change it has highlighted a number of new ways of working and identified areas where accuracy is required and is being addressed, a workplan is in place along with education of staff, the workshops have commenced within November.

There are a number of areas where the RN/ HCA or both fell below planned levels, and there are also a few areas where the RN/HCA was above planned levels.

Where the ward RN levels are below planned, the clinical areas review the shifts and take action to deploy staff in other roles where this is possible or provide a HCA to support the area on the basis of risk, acuity and dependency of the area. Where the area is above planned levels this has been due to ward areas opening in view of the

The matrons and clinical site team balances rota pressures and organisational pressures across the organisation and discussions and reviews are informed at the control meetings throughout the day.

There has been a slight decrease since last month on the number of areas where the actual RN/HCA or both have fallen below the planned levels (13/23 = 56.5%). There are 2/23 that are above the planned levels for RN – this will be due to additional capacity and acuity of patients. There are a several reasons for the number of areas that have a reduction within their actual in relation to their planned registered nursing numbers.

These include:

- Escalation areas opening due to increased internal operational flow pressure – OPEL 3 and 4 on more than 90% of the month
- Ensure robust temporary nursing staffing controls to maintain quality and safety and also manage our financial position in relation to temporary staffing usage.
- Staff have left the organisation or moved to another ward area
- Temporary staffing are unable to fill some of the shifts
- Safecare has enabled accuracy and robustness of acuity and dependency

Actions over next quarter:

- Evaluation of reduction of unregistered staff undertaking enhanced supervision, and the further development of a programme of work .
- Development of the Recruitment, Retention and resourcing plan to be visibile across the organisation
- Overseas recruitment trajectory will see more Registered nurses join the trust between January and February 2020.
- Visibility and scrutiny of temporary staffing usage for the right reason.

Teams are working to reduce reliance on the Thornbury agency through the approval process and scrutiny of every shift.

2.2 Organisational Alert status

This report includes an overview of the organisational Opel status which provides an indicator of the operational pressures present within the system, and therefore is a proxy indicator of the effects on clinical staffing.

The alert status for the organisation for December 2019 is summarised in the table below, with the detail for November 2019 shown in brackets. The table demonstrates that during December the Trust experienced slightly less days at Opel 3 and Opel 4, with much more in Opel 1 and 2.

Overall the Trust experienced 48% of the time in Opel 3 in comparison to last month which saw 60% demonstrating 23 days out of 31 in either Opel 3 or Opel 4, which was 74% of the month.

TSDFT Alert Status December 2019	***No Days in Month***	***% days in Month***
Opel 1	***1(0)***	***3.2% (0%)***
Opel 2	***7(3)***	***22.5% (10%)***
Opel 3	***15(18)***	***48.3% (60%)***
Opel 4	***8(9)***	***25.8% (30%)***

2.3 Newton Abbot ISU - Emergency Department

The department is continuing to use resources from temporary staffing, including use of nursing agencies to maintain staffing levels until the effects of returns from short and long term sickness and including recruitment are fully realised and effective. The staffing skill mix is consistently balanced across the EAUs and ED with the senior nursing leaders ensuring this occurs.

Actions:

- The Baseline Emergency Staffing Tool (BEST) was used in 2016/17 to ensure staffing establishment was appropriate. At that time establishment was within expected benchmark but there were recommendations about shift pattern changes. This will be repeated within the next quarter to determine the skill mix and shifts timings, so that ED are fully informed and up to date with national guidance
- Interim solutions to increase operational and nursing capacity have been sourced with one interim focussing on transformation and one on operational effectiveness. The output is not to further describe the issues but to develop solutions and a plan that will deliver improvement.
- The Trust has sought mutual aid with local partners and an experienced ED nurse has joined the team for 3 months to focus on clinical practice standards.

2.4 Nursing Agency spend

Table A: Nursing Agency Cap, currently at £2,869K full year based on 19/20 Trust submission to NHSI. M9 plan value is £204K which is higher than last month; year to date amount is £2,276K.

A Plan	*Agency Cap submitted to NHS Improvement (NHSI) £2,869K*												
Month	***April***	***May***	***June***	***July***	***August***	***September***	***October***	***November***	***December***	***January***	***February***	***March***	***FY 2019-20***
In month £K	284	284	284	284	284	284	184	184	204	204	204	185	2,869
Year to Date £K	284	568	852	1,136	1,420	1,704	1,888	2,072	2,276	2,480	2,684	2,869	

Table B: Actual usage in Month is £296K, this is £24K higher than previous month's usage. This presents 6.0% of total M9 Nursing spend of £4,937K. Year to date spend is £2,664K.

B	*Actual Year to Date Nursing Agency Spend £K*												
Month	***April***	***May***	***June***	***July***	***August***	***September***	***October***	***November***	***December***	***January***	***February***	***March***	***FY 2019-20***
Spend in Month £K	364	292	303	295	235	338	269	272	296				2,664
Total Nursing Spend £K	5,415	4,986	4,982	4,995	4,873	4,937	4,929	4,920	4,937				44,974
% Agency over Total	7%	5.9%	6.1%	5.9%	4.8%	6.8%	5.5%	5.5%	6.0%	#DIV/0!	#DIV/0!	#DIV/0!	5.9%
Year to Date Spend £K	364	656	959	1,254	1,489	1,827	2,096	2,368	2,664	2,664	2,664	2,664	

Table C: Actual spend to date is above the target (£388K), representing 17.05% adverse against the cap.

C	*Variance Agency Cap versus Actual Spend £K (B-A) - (Overspend)/Underspend*												
Month	***April***	***May***	***June***	***July***	***August***	***September***	***October***	***November***	***December***	***January***	***February***	***March***	***FY 2019-20***
in Month £K	80	8	19	11	(49)	54	85	88	92				388
Year to Date £K	80	88	107	118	69	123	208	296	388				
Distance from Cap %	28.17%	15.49%	12.56%	10.39%	4.86%	7.22%	11.02%	14.29%	17.05%	0.00%	0.00%	0.00%	
UOR* Agency Rating	3	2	2	2	2	2	2	2	2				

Table D: The projected full year spend as at end of M9 (based on assessment of Finance Team) is £3,620K which is £751K higher than the cap.

D	*Forecast for FY 2019/20 - based on Actual Spend M1 to M9, Projected spend M10 to M12*												
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Total
Month	***April***	***May***	***June***	***July***	***August***	***September***	***October***	***November***	***December***	***January***	***February***	***March***	***FY 2019-20***
Full Year Forecast £K	364	292	303	295	235	338	269	272	296	349	331	276	3,620

Nursing Agency Usage by month (£) and cost centre

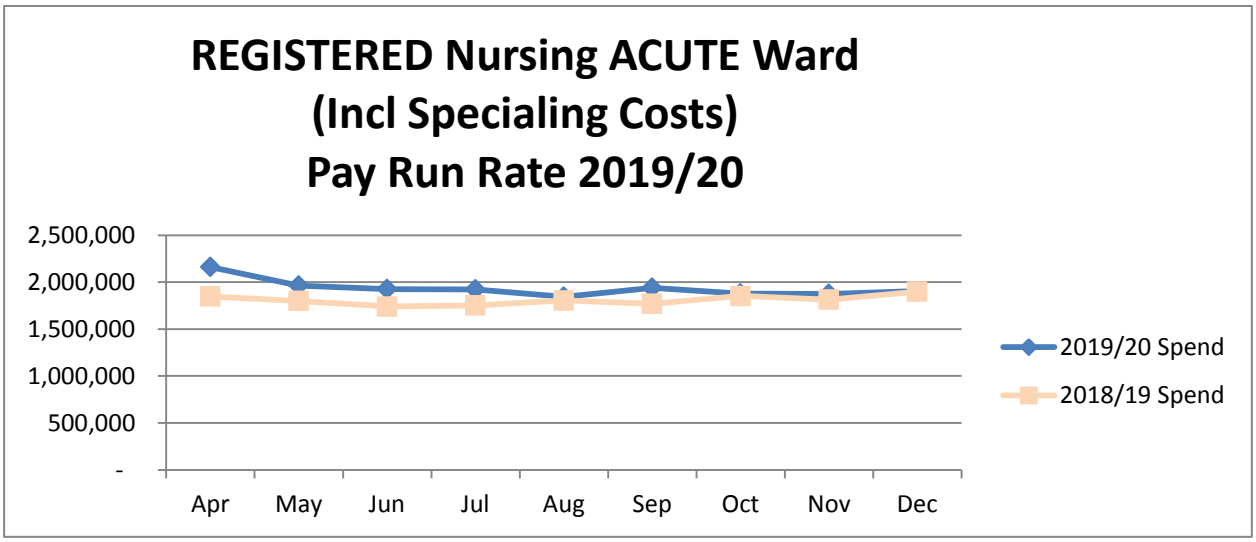
The top 3 spending areas are highlighted below:

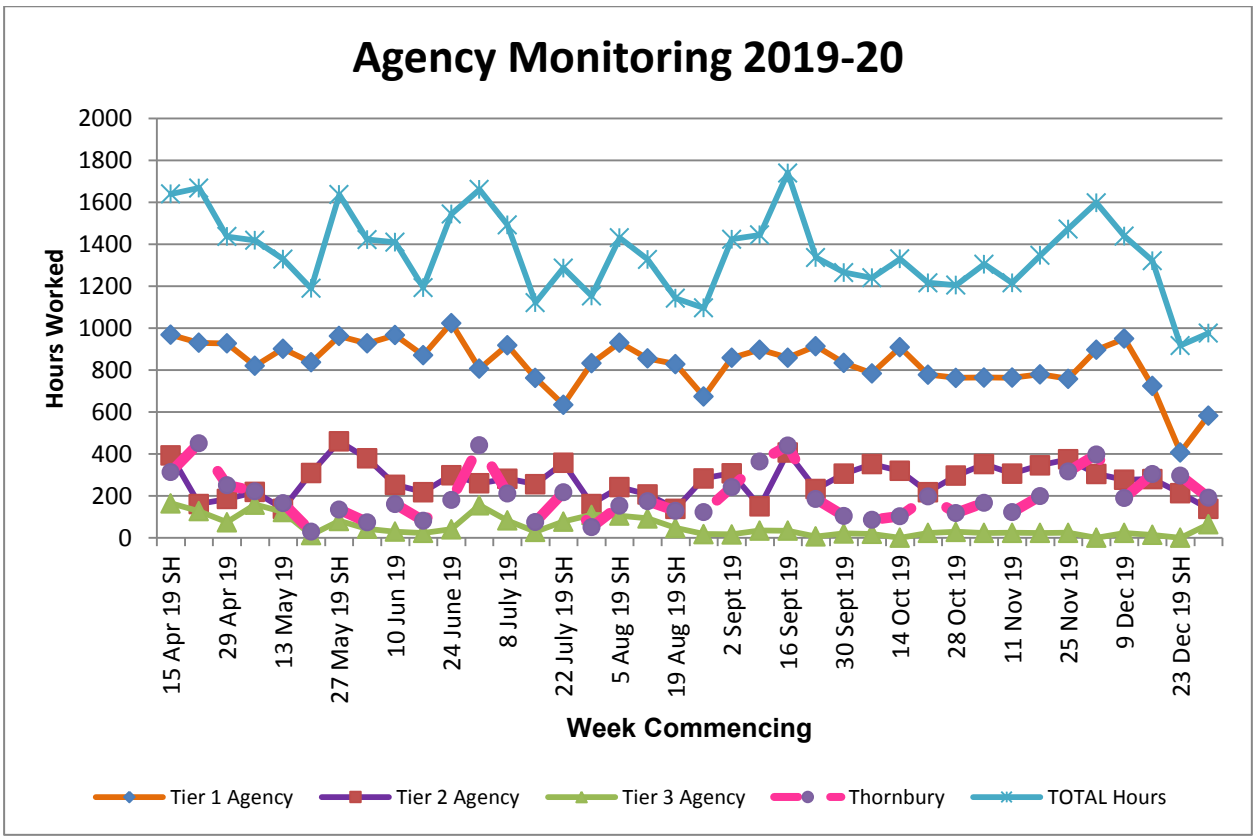
- Emergency Department (comprising A&E, EAU 3&4, AMU and Emergency Practitioners) has the highest usage at YTD £1,257K (47.2%)
- George Earle Ward YTD £ 217K (8.2%)
- Simpson Ward YTD £ 169K (6.3%)

There is increase in spend in month in Louisa Cary Ward due to winter escalation and covering maternity, sickness and vacancies.

There is significant underspend in ward and non-bed based nursing establishment budgets which offsets the overspend on agency. December figures suggest an overall RN budget for bed based care is £217K over budgeted establishment. For non-bed based RN there is an underspend of £703,687.

Agency spend is tracked daily and reported weekly, current data shows a variable use but with overall stability:





There is significant overspend on non-registered HCA of £1,229.583 for bed based care and a small overspend of £2,265 in non-bed based areas. This is exclusively bank spend and related to back fill for RN shifts where appropriate, sickness cover, support for specialing and CAMHS and to support emergency flow.

Actions:

- The winter bank payment was approved and commenced on 20th December.
- As previously mentioned we have a further 25 registered nurses from our international recruitment starting between January and March 2020, this will provide a reduction of temporary staff and agency.
- Ongoing recruitment and retention plans are being developed to form part of the People Plan but will also have a revised delivery plan with achievable milestones

2.5 Nursing and midwifery vacancies

The recruitment strategies previously reported have resulted in an RN vacancy rate as at the end of December 2019 has increased slightly to 10.5% from 9.8%. Registered midwives continue with a <1% vacancy rate.

Actions:

- As a trust we continue on the NHSI Retention Collaborative; the plans of this will be reported through Executive Directors meeting and the People Committee. Staff interviews and phone call exit interviews are being undertaken as a test of change, learning from this is being evaluated presently.

- Our international recruitment continues to see new starters within the organisation and a trajectory of a further 25 joining the Trust from Jan - March 2020, we have seen our first 7 arrive in November and a further number has arrived in December 2019.
- We are reviewing skill mixes within areas to identify new ways of working to provide different opportunities to our staff
- A robust recruitment and marketing strategy is being completed in alignment with the NHS long term plan and NHS interim People plan, for short, medium and long term recruitment, a draft will be in a position to present in January/February 2020.
- Across the STP our Nursing vacancies have been consistently lower than our partners and we continue to monitor this with our internal recruitment and retention.

2.6 Electronic - E-rostering

There are 6 Key Performance indicators that monitor the efficiency and effectiveness of E-rostering across the Trust, these are below.

1. Rosters published 6 weeks prior to commencement
2. All contractual hrs are utilised when fully approval
3. All contractual hrs are utilised before over time assigned
4. Management hrs in line with Rostering guidelines
5. No of staff using employee online to request
6. Identifying areas that are not finalising payroll on time

The two areas of focus include KPI 1 and 2 for inpatient ward areas in order to assist with reducing the usage of temporary staffing. KPI 1: Rosters published 6 weeks prior to commencement or KPI 2: All contractual hrs are utilised when fully approval. A review of the KPIs are being undertaken with presentation of findings with a proposal of measuring some different KPIs will be presented in January 2020.

Actions over the next month:

- A twice monthly ‘grip and control’ meeting has been commenced to review KPI’s for rostering, temporary staffing and recruitment. In order to review progress and measure intervention impact
- Review impact measures and triangulate with temporary staffing utilisation and spend

2.7 Quality and Safety

QuESTT

Each clinical area completes the monthly QuESTT tool which triggers actions as highlighted in the escalation procedure. The Associate Directors of Nursing and Professional Practice ensures contact is made for any area triggering an amber score or above and that appropriate actions to mitigate the issues causing the increase in scores is taken, these are reported as part of the governance accountability framework to all relevant forums.

For December 2019, the table below show that at the time the data was compiled 3 areas had not made a return this month, this has been addressed with the areas and matrons responsible.

There were 0 Red rated teams and 10 teams with an amber rating for December 2019 are as detailed below:

Amber rated teams:

- Brixham hospital – remains amber, however short term sickness and vacancies remain a factor
- Brixham and Paignton nursing – vacancy and short term sickness
- Moor to Sea nursing – vacancy and short term sickness
- Coastal nursing – short term sickness and vacancy
- Newton Abbot nursing – short term sickness
- Cheetham Hill– vacancies and short and long term sickness
- Warrington – new ward opened due to winter planning, new team and ward sister, vacancies and short term sickness,
- Podiatry – have shown an improvement as they have been red for a few months, now amber due to number of vacancies, short term sickness
- Social Care - HADT– due to number of referrals, vacancies, short term sickness
- Social Care - Torquay –due to number of referrals, vacancies and short term sickness

The main themes as described above are nursing vacancies and short term sickness, alongside the number of appraisals outstanding. Workforce and organisational development are working alongside the departments, sisters, matrons and associate directors of nursing and professional practice to develop action plans, which are being submitted to design a recruitment and retention strategy and workforce redesign.

The tables showing QuESTT scores for each clinical area are shown below.

Quality Safety and Effectiveness Trigger Tool (QuESTT)

Torbay and South Devon NHS
NHS Foundation Trust

Service Rating	Level 0	Level 1	Level 2	Level 3
C. Hospital & MIU	<12	12-16	17-25	>25
Other	<16	16-24	25-35	>35

Service Type	Team	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019
% Complete		92%	95%	95%	99%	96%	93%	99%	95%	96%	98%	98%	96%
Total Purple (L3)		0	0	0	0	0	0	0	0	0	0	0	0
Total Red (L2)		0	0	0	0	0	0	2	2	2	0	0	0
Total Amber (L1)		10	9	8	8	8	5	8	10	5	10	9	10
Total Green (L0)		66	70	71	74	72	72	72	67	73	71	72	70
Average Score		10.0	10.0	9.5	8.8	9.4	9.6	10.0	10.2	9.7	10.0	9.4	10.3
Acute	Ainslie	12	11	10	8	13	12	11	10	11	10	7	10
	Allerton	15	12	13	16	8	16	13	12	14	9	6	5
	AMU		8	7	13	14	5	5	11	6	8	6	8
	Anaesthetics	10	8	7	8	11	10	11	11	10	7	9	8
	Breast Care Unit	6		4	3	0	2	0	6	10	6	3	5
	Cath Lab	3	10	0	7	4	10	10	10	13	15	7	6
	Cheetham Hill	17	14	17	16	16	15	11	13	12	13	13	17
	Cromie	15	16	11	10	10	7	12	7	5	8	5	9
	DSU	9	13	10	13	13	14	10	9	12	15	13	9
	Dunlop	5	3	5	7	3	5	4	5	6	7	6	7
	Early Pregnancy / Fertility Service	2		2	2	4	4	6	6	6	6	8	6
	EAU3	13	10	11	8	8		12		12	10	18	14
	EAU4	7	10	8	11	8	7	18	11	8	7	6	5
	Ella Rowcroft	10	9	11	10	3	10	12	8	10	9	8	11
	Emergency Department	21	19	14	16	15	15	18	20	19	19	18	15
	Endoscopy	8	7	5	2	4	4	3	8	6	8	3	3
	Forrest	13	12	13	10	15	14	12	8	8	15	7	10
	General Theatres		11	9	9	11	11	9		15	7	15	13
	George Earle	12	12	10	10	11	11	11	13	15		16	14
	Gynaecology Out-Patients Dept	6		2	6	8	9	9	7	7	8	3	7
	Hutchings		4	8	7	9	12	13	8	9	9	9	7
	ICU	8	6	11	8	7	9	11	9	3	9	14	6
	Louisa Cary	2	2	15	8	4		6	7	3	9	3	
	MAT / TAIRU	4	3	10	5	10	10	10	9	4	7	7	8
	Maternity	13	8	11	5	7	13	12	12	14	13	9	9
	Midgley		15	15	7	11	14	9	3	7	9	8	11
	OPD	4	6	4	2	2	6	6	6	3	2	4	6
	Ophthalmology	9		12	9	13	8	15	15	13	14	13	15
	Ortho Theatres	15	14	15	16		15	14	13	14	15	14	12
	Pre-assessment	6	4	6	6	8	8	8	10	12	16	14	12
	Radiology	14	13	14	10	13		9	11	9	14	10	9
	Recovery	9	8	8	5	8	12	8	10	11	15	15	14
	RGDU	15	5	5	7	10	7	13	15	12	9	7	10
	SCBU	9	11	3	10	2		4	2	1	3	5	
	Sexual Health	8	11	11		8	13	11	10	5	6	6	12
	Simpson	7	8	12	14	8	9	8	11	11	9	11	12
	TCCU	5	5	8	7	3	5	4	8	9	14	10	6
	Turner	8	9	12	9	11	9	8		7	12	9	13
	Urology	17	14		5	14		7	10	4	6	5	10
	Warrington	8	6	3	6	3							16

Service Type	Team	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019
Community Hospital	Brixham	8	11	8	15	13	7	20	19	17	14	16	14
	Dawlish	5	3	7	6	7	0	1	0	3	3	3	5
	Newton Abbot Teign	14	10	9	9	11	16	11	16	9	7	10	10
	Newton Abbot Templar	5	8	9	7	4	9	7	2	9	9	9	10
	Totnes	8	7	8	8	7	7	6	12	9	7	11	8
MIU	Dawlish	6	6	5	7	9	14	12	14	9	9	12	11
	Newton Abbot	5	5	2	0	6	8	8	8	6	7	8	8
	Totnes	0	0	5	2	8	7	3	9	6	8	4	4
Community Stroke and Neurology	Torbay and South Devon	13	15	18	16	14	14	16	14		10	10	
Infection Control	Infection Control	11	13	13	11	11	4	6	8	3	4	6	6
LLTS	LLTS	7	7	6	8	7	6	7	6	5	6	8	6
Nursing	Brixham and Paignton	16	12	16	14	12	14	9	12	15	22	19	24
	Coastal	13	18	17	13	13	14	11	19	15	17	15	17
	Moor to Sea	14	23	12	6	7	10	12	15	8	15	20	16
	Newton Abbot	18	15	15	12	11	10	14	19	15	11	15	20
	Torquay	9	9	6	6	6	9	11	6	9	12	17	9
OOH Nursing	OOH Nursing	20	22	22	9	17	9	12	14	13	16	14	12
Specialist Nursing	Specialist Nursing		4	4	5	1	7	2	4	5	6	8	12
Occupational Therapy	Brixham and Paignton	16	18	14	12	12	12	14	10	12	12	8	8
	Coastal	21	15	23	18	11	8	10	10	9	5	7	6
	Moor-to-sea	14	10	6	10	14	6	14	10	17	8	14	14
	Newton Abbot	7	5		8		11	9	19	13	19	9	13
	Torquay	0	4	2	6	8	4	2	4	4	6	6	8
Physiotherapy	Brixham and Paignton		14	12	12	6	10	8	9	12	7	7	10
	Coastal	18	19	12	14	15	8	16	13	9	11	5	8
	Moor-to-sea	12	6	14	10	12	8	14	12	19	14	14	14
	Newton Abbot	9	9		12		11	9	17	11	13	9	9
	Torquay	11	22	10	11	10	12	10	8	10	6	6	10
Podiatry	Podiatry	14	23	22	20	22	23	32	26	27	22	22	24
Public Health - Lifestyles	Lifestyles	5	4	1	7	5	11	3	0	7	5	1	5
Public Health - Nursing	Paignton and Brixham	10	12	10	10	8	6	6	6	8	4	4	6
	School Nursing	5	7	6	5	7	6	7	7	5	8	12	12
	Torquay	4	5	2	2	2	2	5	4	4	2	6	6
Public Health - Substance Misuse	Substance Misuse	6	4	4	4	6	8	10	6	4	4	2	0
Social Care	Brixham and Paignton	14	10	11	8	12	10	12	10	10	14		10
	Dawlish & Teignmouth	14	6	10	2	8	10	12	12	14	18	12	14
	HADT - S. Devon	15	11	11	13	17	15	17	13	17	13	13	15
	HADT - Torbay	11	9	17	5	11	13	8	13	10	9	7	17
	Newton Abbot	14	12		8	18	18	16	16	16	10	10	14
	Older People Mental Health - Torbay	2	4	0	4	10	4	8	4		2	2	0
	Torquay		6	10	12	16	12	10	16	12	10	14	16
	Totnes & Dartmouth	11	15	14	10	19	8	16	8	4	16	10	12
Tissue Viability	Tissue Viability	10	13	7	14	10	7	7	9	8	8	8	8

3. Conclusion

This report demonstrates that there are a number of safety measures in place to ensure that nursing establishments and fill rates are monitored and appropriate action is taken to maintain staffing levels. These are robustly actioned both by the specialty matrons and senior sisters, alongside through the control room function.

This paper assures the Trust board that there is nursing and midwifery safe staffing in all inpatient areas within the Trust. The information is triangulated with the quality and safety metrics which demonstrate that these remain within the national requirements.

4. Recommendation

The Board is asked to note the report.

Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Trust Quality Accounts			Meeting date: 5th February 2020
Report appendix	None		
Report sponsor	Chief Nurse		
Report author	Associate Director, Quality Improvement		
Report provenance	Triangle of Care Steering Group IT Clinical User Group Community IT project Group		
Purpose of the report and key issues for consideration/decision	This report provides an update against the 3 agreed Trust Quality Account priorities which are published as part of the Trust Annual Report and Account. Priority 1: EPMA (Patient safety) Priority 2: Community IT system rollout (Clinical effectiveness) Priority 3: Carers & the Urgent & emergency care pathway (Patient experience)		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to receive and note the report.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	x	**Valuing our workforce**	x
Improved wellbeing through partnership	x	**Well-led**	x

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework		**Risk score**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	**x**	**Terms of Authorisation**	**x**
NHS Improvement	**x**	**Legislation**	**x**
NHS England	**x**	**National policy/guidance**	**x**

Report title: Trust Quality Accounts: Quarter 3		5th February 2020
Report sponsor	Chief Nurse	
Report author	Associate Director, Quality Improvement	

1. Introduction

Quarterly update of Trust Quality Account for the 3 priorities the Board have signed off and the Trust is publicly accountable for delivering.

2. Discussion

No	Priorities	Quarter 1	Quarter 2	Quarter 3
1	To change our inpatient prescribing for people in hospital inpatient beds across the ICO to our commissioned electronic prescribing and medicines administration programme (EPMA) by 31 December 2019.	Objectives not met	Objectives not met	Objectives not met
2	To implement roll out of Community IT clinical system to Coastal and Newton Abbot	Objectives off plan with actions	Objectives met	Objectives met
3	To improve the Carers' experience for themselves and their families receiving care across the urgent and emergency care pathway	Objectives met	Objectives met	Objectives met

2.1 Priority 1: EPMA

2.1.1 The objectives for quarter 3 were:

- Resolution of IT issues
- Version 4 testing
- Resolution of EPMA specific identified issues e.g. reporting

2.1.2 The objectives were not met. With regards to resolution of IT issues & version 4 testing:

- Tablets: All EPMA tablets were collected and work ongoing to rebuild and reconfigure the. The new configuration has been tested successfully by the EPMA Team and this will now be tested on Turner Ward who are the only

ward still using EPMA in the hospital.

- Laptops: IT is schedule to reconfigure all EPMA laptops through January-March 2020.

- Ward PC: All Trust PCs are in the process of being replaced to new windows 10 machines. This work has started and will progress into 20/21.

- Version 4 of the EPMA software has still not been released. The issue has now been escalated the Chief Operating Officer to agree a way forward with the supplier.

2.1.3 With regards to the resolution of EPMA specific identified issues:

- Good progress has been made with developing three new EPMA prescriptions; insulin, oxygen and warfarin.

- The EPMA team are exploring the development of VTE assessment on EPMA. The Trust is currently under reporting against this assessment.

- The team are testing an EPMA solution for the ED Department.

2.1.4 Risks continue to be managed through the EPMA Project Board. Quarter 4 plans include:

- Agreement of new timelines with EPMA supplier for :

    - Version 4
    - Lab interface for INR (needed for warfarin prescription)
    - VTE assessment recording
    - Paediatric double weight checking
    - GP medications interface
    - API link from the Trust's Clinical Portal

- Basic scenario testing of the Symphony ED to EPMA interface

- Testing of the Trust EPMA data-warehouse for reporting

- Approval of the revised EPMA business case and change management programme.

- Resolution of IT issues on the tablets and laptops. Ward desktop PC's are dependent on PACS being upgraded to a windows 10 compliant version – Q1 20/21

2.2 Priority 2: Roll out of Community IT clinical system to Coastal and Newton Abbot

2.2.1 The objective for quarter 3 was to go live in the Newton Abbot locality for the teams trained in quarter 2. The objective was met.

2.2.2 Quarter 3 achievements were:

- Migration of patient records from the active community caseload for Newton Abbot IC and Therapies on to SystmOne.
- Migration of patient records from active community caseload for Moor to Sea Therapies, Community Nursing and Matrons and Newton Abbot Community Nursing and Matrons
- Training and go live with Newton Abbot locality teams trained in quarter 2 and Moor to Sea teams trained in quarter 3.

2.2.3 **Quarter 4 plans:**

- Revisit Event Detail (activity) recording within South Devon locality due to issues identified with reporting
- Commence gap analysis of SystmOne and EMIS (EMIS Community is currently in use within Torbay to enable GPs to view information regarding their patients)
- Scope further services that have been requested by the Community IT Project Board to be added to SystmOne.

2.2.4 Risks continue to managed through the Project Board with proactive mitigation from the Group.

2.3 Priority 3: To improve the Carers' experience for themselves and their families receiving care across the urgent and emergency care pathway

2.3.1 The quarter 3 requirements were met. Work includes:

- Conclusion of carers ED survey.
- Service activated to enable carers to be supported when they need to bring a patient into ED and park their car.
- Ongoing work to embed existing support to Carers such as the Orange Lanyard and Hospital Passport (IRIS campaign – Identify, Record, Involve, Support)
- Ongoing work to utilise Healthwatch's rate and review cards with volunteers / Carers supporters in the Emergency Department to gain feedback and

identify issues

- Ongoing work with regards to carers awareness training across urgent & emergency care.

2.3.2 In addition:

- The sitting service has been set up to provide patients who require close attention due to their ongoing health condition with someone to accompany them while their Carer parks their car. The issue was raised within the conversations Family Carer Supporters in ED had with Carers. The service is advertised in the ED waiting room and in Signposts for Carers newsletter.

- Posters on the most efficient way of recording Carers on Symphony have been hung up in ED for staff to refer to.

- Carer Awareness sessions for ED staff are planned for Q4 and have taken place with SWASFT in Q3. SWASFT offered to hand people they identify as Carers packs with information on Carers Services and orange lanyards so they can easily be identified in ED and through the hospital pathway. These have been put together and given to SWASFT.

2.3.3 Quarter 4 plans include reporting on the evaluation findings and publishing a leaflet on what carers can expect in ED.

3. Recommendation

Board of Directors is asked to receive and note the report.

Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Report of the Chief Operating Officer			**Meeting date:** 5th February 2020
Report sponsor	Chief Operating Officer		
Report author	Torbay System Director		
Report provenance	Contents reflect latest updates from management leads across all ISUs		
Purpose of the report and key issues for consideration/decision	To provide a broad narrative operational update to complement monthly operational reports including performance metrics.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	Receive and note the report.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership		**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework		**Risk score**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	**x**	**Terms of Authorisation**	
NHS Improvement	**x**	**Legislation**	
NHS England	**x**	**National policy/guidance**	

Report title: Report of the Chief Operating Officer		**Meeting date:** 5 February 2020
Report sponsor	Chief Operating Officer	
Report author	Torbay System Director	

1. Purpose

To report on key operational issues to include:

- assurance on the control mechanisms in place to deliver the financial stability and progress towards the business planning requirement;
- information on operational areas not focussed on with the integrated performance framework; and
- an update on the winter reset impact and actions.

2. Financial governance - Grip and Control

The Torbay and South system teams continue to meet weekly with professional and operational leads detailing progress in delivering efficiencies and monitoring progress with delivery targets. The systems also work together on trust wide initiatives, for example the intermediate care efficiency programme. The weekly finance delivery group covers the outputs of the grip and control work and all activity is recorded for monitoring using SmartSheet. The business planning process has been strengthened using a clear project management office (PMO) function, which will be refreshing its controls and processes in the coming weeks. All operational leads are involved in a bottom-up budget process, matching capacity and demand with a clear brief for transformation of services.

3. Contract update- Living well@home progress update

The last report updated on the change of contract on 1st April from Mears. A short extension on the market engagement has been added to enable provider dialogue on the Key Performance Indicators. The team has been set up ready to review the applications w/c 27th January this will take two weeks to complete allowing the contracts to be issued. Detailed work on the transition plans for contracts is in preparation. As part of the enabling and delivery of the Living well@home model Torquay ISU in partnership with the Council have been setting up the Arranging Support Team (AST).

4. Arranging Support Team and Strata

The Arranging Support Team will centralise, speed up and provide more control over the process of helping people where the need for extra support has been assessed. This may include home based care or a care placement. Strata is a web-based support tool bringing information on care home and other capacity into one place to support this process.

The team framework has been agreed, currently the brokerage function is out to advertisement. Work is progressing well with Strata to produce a cloud-based pathway to match patient profiles with the care providers' information base. Licences between the allocation tool for our rapid teams and our brokers are being set up to maximise the allocation of capacity and support flow.

The planned outcomes measures built into the delivery model will manage the market with demand/capacity and pricing, reduce the number of insourced POC by 20% and impact on the length of stay by .5 day. There is an important clinician outcome in terms of their time back to deliver Face to Face client input as brokering all domiciliary care and short-term placements will be led by the arranging support team. Successful delivery will be evident though there are a number of outcome measures which will be monitored through the Torquay ISU and through to the integrated governance group.

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5. Adult Social Care improvement delivery

There has been the development of a Joint programme management office function between the council and ICO to enable a corporate approach for managing change initiatives supporting Adult Social Care in Torbay. This will ensure oversight and governance including:

- Review, support and guide during delivery
- Supporting effective and efficient management of programmes/projects
- Support the challenge/scrutiny and ensure alignment with strategic objectives
- Provide independence for the Social Care Programme Board (avoiding surprises through risk management)
- Develop an approach to feeding the lessons learned
- Continuous improvement methodology shifting the emphasis from a yes/no task and finish to a data driven approach using SPC/run charts to enable effective decision making. This will feed through SCPB into Integrated Governance Group

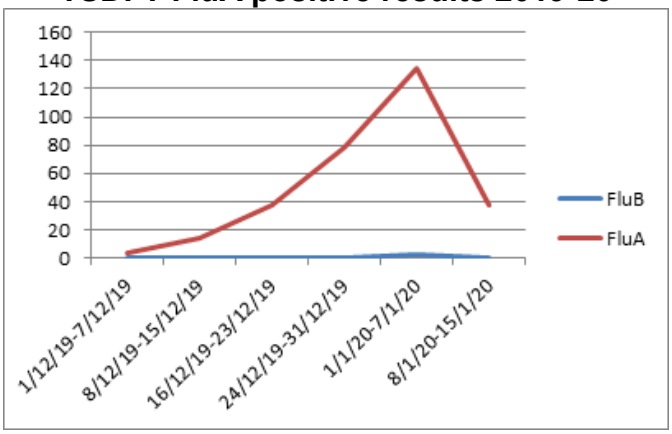
6. Winter updates

6.1 **Flu**

In terms of patient presentations, the ICO has experienced a high number at New Year but numbers have greatly reduced in recent days. The management of flu and cohort bays has worked well resulting in no flu ward outbreaks/closures A total of 228 positive Flu tests so far this season.

During the week of 8 Jan to 15 January, only 55% of positive Flu A patients were admitted. The Director of Infection Prevention and Control continues with messaging to doctors that flu testing is not a diagnostic and should be done for admitting purposes to manage isolation.

TSDFT FluA positive results 2019-20



6.2 **Staffing**

Challenges during the festive fortnight. Winter initiative payments launched early to maximise cover. This has been helpful in filling shifts and reducing agency.

6.3 **Ambulance Handovers**

There has been an increase in ambulance arrivals, the additional paramedic capacity is impacting on arrival times particularly improved response times to GP referrals. The earlier in the day ambulance arrivals has been beneficial in managing GP patients however the ED have experienced significant bunching which has caused significant pressure. An urgent recovery plan has been developed to mitigate this increased risk.

6.4 **HALO**

The planned Ambulance Trust Hospital Liaison Officer (HALO) presence in the Emergency Department has been a positive winter initiative in terms of relationship building. This has demonstrated the need for further work recommended in terms of coaching and understanding alternatives to conveyance for paramedics.

6.5 **Silver System Re-set**

There is ongoing work led by the Head of Operations to optimise flow and minimise ED crowding. Headline principles include:

- Control room information with a clear action-orientated process.
- Focus on afternoon Safer huddles
- identification and management of early discharge “gold patients”.
- Focus on 21 day and 10 day LoS.
- Maximise discharge for fit to transfer patients.
- Internal professional standards.
- Supporting morning discharges with greater emphasis as SWASFT demand is shifting towards earlier in the day.
- Weekend discharges – Saturday and Sunday medical discharge numbers remain a challenge in terms of maintaining flow at weekends:
- Clinical co-ordination: clear criteria-led discharge plans on Friday which will be managed at the weekend.
- Clinical triage of medical tasks from the wards
- Management of weekend support teams by clinical co-ordinator.

- H@N review ongoing with doctors, physicians' assistants working with clinical site team to scope potential night improvements.
- Community services:
- Earlier referral to the discharge hub and maintain referral focus at weekends.
- Focus on supporting community services to bridge the domiciliary care gap.
- Overnight re-settling discharge service using PTS crew to maximise safety of late discharges.
- Connections between teams and communication across networks continue to add value and make a difference.

6.6 **Lessons from Festive Bank Holiday period**

A review of the festive fortnight has been commenced through the Friday winter meetings. The aim is to understand from specialty leads what was done in terms of Bank Holiday resilience preparation and what more could have been done, particularly at times when demand was predictably high. This information and lessons learnt by specialty teams will be used as a template to inform planning for the February half-term.

6.7 **ECIST**

The Trust continues to work with various members of the emergency care intensive support team including improvement managers and workforce experts. The ECIST Medical Director will be visiting the Trust and working closely with The System Medical Directors to provide advice and guidance on our medical model.

6.8 **Regular Assurance**

The COO/Head of Operations and Director of Commissioning Devon CCG review 10 performance indicators. These indicators are derived from the ECIST weekly flow dashboard and are recognised metrics contributing to 4-hour performance and system pressure. If on two consecutive days 4 or more measures are triggered mitigating actions are agreed.

6.9 **Ambulance Handovers**

Work continues to maintain the high priority around improved management of ambulance handovers. A system requirement has been acknowledged, to clearly outline how teams work together to generate capacity at times of significant ambulance demand by:

- maximising 'fit to sit' principles in ED;
- safe use of clinical space across ED, EAUs and AMU;
- generating surge capacity on the wards to enable a more pre-emptive response to overcrowding through increased ambulance conveyance an urgent review of internal escalations has been commenced.

6.10 **Winter capital and revenue allocations**

NHSI/E through the STP asked for submissions to improve urgent and emergency care performance, the organisation was successful in bidding for winter revenue funding £701k which is also required to be spent by 31st March 2020 to support the revenue costs associated with the capital spend already allocated £500k. These schemes combined with additional social care funding are as below. Each scheme will be monitored through the CCG and PMO mechanisms across TSD and primary care as these are whole system delivery schemes.

One of the key focuses of the funding was to reduce crowding in ED. A detailed business case for a surgical assessment unit SAU has been approved to enable all surgical GP referred patients as well as streamed to surgery patients to be redirected from ED. The building works to create the physical space will take a further 10 weeks, currently alternative temporary options are being agreed to achieve this aim. The clinical teams are developing a solution to support the emergency department as a matter of urgency. A trial to support this crowding reduction will be in place imminently using the winter pressure monies received. All other schemes have been commenced to support safe and effective care and flow across the organisation. The schemes are identified below:

- Resettlement team -7-day outreach. This project aims to support clients back to their care/nursing home at weekends.
- Increase discharge hub at TSDFT to 6 days to improve flow.
- High impact users- scheme to coach/support reduction in use of ED A Co-Designed Framework and flow chart is in place
- Develop voluntary sector capacity to support hospital discharge & admission avoidance
- Develop end of life support for personal care workers/agencies in conjunction with Rowcroft hospice.
- Block book end of life personal care
- Advanced care planning for patients admitted within 1 year of end of life by specialist nurses
- GP visiting & support to care homes In place across the 5 localities.
- Low intake dehydration scheme in care homes
- Development of surgical admissions and ambulatory assessment unit
- Additional senior capacity in ED Clinical and managerial support.
- Enhancing ward areas to improve before midday discharges Additional chairs and reclining trollies have been purchased.
- Additional transport capacity. This has been the addition of a PTS vehicle with an HCA to facilitate over night discharge straight from ED.
- Extra medical cover over weekends to support discharges.
- Restore 2 (part of delivering enhanced health in care homes)
- Extra nurse to support our respiratory ward over winter
- Community therapy in reach, an experienced community therapist has joined the site team.
- Staff wellbeing

The Devon A+E delivery board and CCG are providing the oversight on delivery and outcomes of the agreed impacts of the investment. Progress including outcomes and impacts will be detailed in the COO report in March 2020.

7. **Drug and alcohol service tender**

In early December the commissioners held an event to discuss future tender process for the drug and alcohol service. Since this an ‘Alliance’ commissioning approach has been agreed by their Senior Management Team. The exact way in which this tender will take place has yet to be agreed but there are two possible favoured options:

- Commission drug and alcohol service individually but with an agreement that the provider will work as part of the Alliance approach within the contract.

- To commission an alliance contract whereby providers will have allied with other services to present their tender as a joint venture.

7.1 **Drug and alcohol Services Performance key headlines**

Successful completions for opiates improved for Q2 from 4.9% to 5.3%. The baseline target moves and next quarter our target will be 5.6%. To be in the top quartile we would need to be at 7.3%. In terms of numbers this equates to a further 10 opiate users completing treatment successfully over 12 weeks.
Re-presentations stayed the same (13.3%) for opiates and improved for Non-opiate down from 8.7% to 5.4% and alcohol from 11.9% down to 11.1%. This represents a general improvement for opiate representations since Q2 2018 where representations peaked at 21.1% (less is better for people representing to treatment). For non-opiate 5.4% representation rate is good.

Changes to the service appear to be improving outcomes and an action plan to continue this improvement remains in place.

8. Recommendation

The Board is asked to note the content and information and provide challenge and seek further assurances as required.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Workforce & Organisational Development Report			Meeting date: 5th February 2020
Report appendix	N/A		
Report sponsor	Director of Workforce and Organisational Development		
Report author	Workforce and Organisational Development Business Partner		
Report provenance	People Committee 9th December 2019		
Purpose of the report and key issues for consideration/decision	• To update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported to People Committee • To provide the Board with assurance on workforce and organisational development issues.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To note the content of this report.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership	X	**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	X	**Risk score**	Multiple
Risk Register	X	**Risk score**	Multiple

External standards affected by this report and associated risks

Care Quality Commission	**X**	**Terms of Authorisation**	
NHS Improvement	**X**	**Legislation**	**X**
NHS England	**X**	**National policy/guidance**	**X**

Report title: Workforce & Organisational Development Report		Meeting date: 5th February 2020
Report sponsor	Director of Workforce and Organisational Development	
Report author	Workforce and Organisational Development Business Partner	

1. Introduction

This report seeks to provide an update to the Board on the activity taking place within the Workforce and Organisational Development Directorate.

2. People Committee - Key Notes

The People Committee met on 9 December 2019. The following summarises discussions and agreed actions:

2.1 People Plan: Members discussed progress with the People Plan and its context and development since the formation of the Integrated Care Organisation (ICO): the current draft was based on the National long-term People Plan. Workforce elements of the Devon Sustainability Transformation Partnership (STP) would also need to be included. It was agreed that staff engagement and buy in was essential.

2.2 Workforce Information Report: Discussions took place around current dashboard and information provided. The conversation focussed around Sickness absence as October 19 sickness absence rate was the highest recorded since 2006. Recognition that it was difficult to quantify Social Care staff sickness separately, as the Trust is an ICO. The highest reason for sickness absence was recorded as stress and various health and wellbeing initiatives were discussed which had been introduced to address this. Acknowledgement of activity taking place looking at an analysis of age-related sickness absence and the reasons for this – the Trust staffing age profile was quite high. There was also acknowledgement about the importance of staff support during absences.

2.3 Talent Management/Succession Report:

2.3.1 The High Potential Scheme (HPS) is being implemented working across the STP.

2.3.2 The Trust has been invited to participate in piloting a Talent Diagnostic Tool, with support from the South West Leadership Academy.

2.3.3 It was agreed for a deep dive of current appraisals to take place and report back at Feb People Committee.

2.4 Recruitment Report: Acknowledged and discussed high levels of Bank / Agency usage. A rolling programme of improvements are being made and barriers to staff recruitment are being identified and addressed. The Terms of Reference (TOR) for the Recruitment Planning and Redesign Group would be brought to the next People Committee.

2.5 Pay Report: was shared and information found useful.

2.6 **Board Assurance Framework (BAF) – Workforce deep-dive:** It was agreed that the group would review a risk at each meeting to cover all the BAF risks in turn. This meeting reviewed "Failure to create an inclusive culture"**.**

2.7 **Medical Workforce – Job Planning: Example:** Conversations have been taking place with Medical Workforce Programme Board on how to develop population-centric workforce planning, developing the workforce model around staff skills and competences. A further report would be brought to a future People Committee.

3. Workforce & OD Directorate Updates

3.1 Our People Plan – Creating a Great Place To Work

3.1.1 On integration of the two predecessor organisations in 2015, Torbay & South Devon NHS FT (TSDFT) developed an Integrated Workforce Strategy. Since that time, the organisation has been on a journey of integration and other national and regional guidance has been published, all with relevance for our workforce. An essential part of the organisational strategy, and our ability to deliver it, is the People element. It is timely, therefore, to review and develop our own People Plan as part of our organisational strategy development.

3.1.2 In order to create a robust People Plan, we will need to reflect on:

1. The content of our National and Devon Long Term Plan (LTP) and Integrated Care System development
2. Our experience of our journey of integration so far, both within our Integrated Care Organisation (ICO) and how it connects with our system/community-successes and challenges
3. Meaningful analysis of our staff and patient experience data

3.1.3 A framework of principles has been developed to co-create our People Plan.

3.1.4 Using this framework there will be an engagement programme which will take the form of listening to and engaging with our people. The approach will include a diverse range of forums and media. Analysis of all the incoming information from these sources will be analysed to inform both our organisational strategy and People Plan, hand in hand.

3.2 Workforce & OD Systems

3.2.3 Rostering: Rosterpro exit on track with all cost centres planned to be removed from Rosterpro by Feb 2020 to free up March for historical report extraction for future proofing of Freedom of Information (FOI) and Audit requirements. New KPI's for Allocate Healthroster identified as agreed with clinical staff to be ratified. Safecare now being utilised in all key clinical areas on completion of full training however more focus as inconsistent use across areas. On-going group training workshops for continued Healthroster support for all modules.

3.2.4 Vacancies: Continuing to support the alignment of Finance data to match the correct Occupation Code groups for improved vacancy reporting accuracy.

3.2.5 Reporting: Huge increase in demand on reporting from ESR with avenues being explored internally using Tableau and externally using a third party to compliment the reporting capabilities of ESR.

3.2.6 Electronic Forms: Medical and Dental Starters and Change of Circumstance Forms to go live in February so all M&D forms will then be electronic, plus all Bank forms to be electronic by Feb/mar timeframe. Improvement and redesign of current forms being undertaken.

3.2.7 Registration Authority: SystemOne roll-out support continuing in Moor to Sea Nursing, Newton Abbot Nursing, and Moor to Sea Intermediate Care which involves issuing smartcards and allocating roles and workgroups for staff. Local smartcard administrators in Newton Abbot, Teignmouth and Totnes have been created so if users lock their cards then they can get them unlocked locally.

3.3 Education & Development:

3.3.1 Simulation Team: The HEE funding for a community simulation VR project has been received, and we have appointed a simulation fellow to undertake this work for two days a week. The fellow has applied for NHS research ethics approval and is awaiting confirmation to study the difference between a simulated caravan and a real physical structure. It is hoped that this research will be used to inform simulation networks nationally of the viability of using VR within community simulation. The team have been supporting medicine with a medical registrar simulation training day that has been observed regionally to highlight how the training that we have instigated could be rolled out regionally. Discussions are taking place with the FTSUG/HR around planning some simulation sessions for managers regarding difficult conversations. Standard simulations for both medical and in situ simulation in both adult emergency and paediatric arenas continue. Plans are underway to run an insitu transfer of patients study day working with teams from A&E, ICU, Anaesthetics and ambulance crews. To aid with the shortfall of nursing staff time, the team have agreed to assist with the

RCOP PACES exams, in assisting patients through the process. Some of the team are acting as external mentors for regional HEE, simulation projects, and have got funding from HEE to assist with this. The team presented a VR simulation workshop at the southwest simulation network conference, highlighting the advanced innovative ways Torbay is leading both regionally and nationally in the emerging field of mixed reality simulation. Feedback was overwhelmingly positive and as such the team have been invited back to run more workshop presentation at the next regional conference.

3.3.2 Apprenticeships: We continue to offer over 29 different clinical and non-clinical apprenticeship standards (from levels 2 to Level 6 BSc and Level 7 Masters); working with 11 different training providers to ensure as many of our employees as possible have the opportunity to develop within their working role. Work has now commenced around the following Apprenticeships: Level 4 Commercial Procurement, Level 6 Biomedical Scientist, Level 2 Decontamination and Level 3 Clinical Coder. The Level 6 BSc Diagnostic Radiographer apprenticeship commences in March 2020 with University of Exeter. We hope to have one learner for this programme, and Lead in Radiography has stated he hopes to be able to offer this opportunity out annually. During the last quarter (Q3 - 1st Oct 2019 – 31st Dec 2019) we had 10 existing employees and new employees join an apprenticeship within our Trust. Q3 is always our lowest quarter for figures. Apprenticeship standards continue to be developed and many more employees are exploring the opportunities being made available to them, providing them with career enhancement and progression.

3.3.3 Widening Participation: Aspire: The 2019/2020 Aspire Cohort remain on track and are all working really well within the Trust. All 7 students, placed within several departments: - Catering, Portering, Waste, Domestic Services and ward based (Cheetham Hill), are exceeding expectations. T Levels (Industry Placements): By September 2020 we hope to offer several Industry Placement opportunities to those undertaking a T Level qualification (Technical Level). In the first instance, these opportunities will be predominantly in areas of Business, I.T. and Digital. Healthcare opportunities should commence in 2021. Work Experience: The work experience process is running well and we continue to work with education providers to facilitate work experience placements for schools and colleges across our area.

3.3.4 Pre-registration Nursing: Most pre-registration nursing students on placement in our trust are now being assessed according to the new NMC Standards. TSDFT Placement Development Team (PDT) have been collaborating with Plymouth and Exeter University teams to roll out of the training to ensure that we have sufficient Practice Assessors and Practice Supervisors trained to support the students. To date we have 337 Assessors, and 248 Supervisors updated on the register. Further courses continue to be offered. The CLiP (Collaborative Learning in Practice) evidence-based model is moving away from the traditional mentor role and towards a coaching-style of learning which utilises goal-setting, questioning, active listening and reflection, to promote student nurses' learning and development. Feedback from students and staff has been generally very positive due to students becoming more involved in their patient's care and developing a deeper, more holistic understanding. Six wards run CLiP: two community-based and four acute wards, with one of the acute wards accepting their first CLiP intake this week. Staff have been preparing for the changes with

the support of the PDT for several months, and both students and the ward will continue to be supported by the PDT to support the change.

3.3.5 Private, Voluntary and Independent Sector: The Education Directorate continue to support the delivery for education and training to the private, voluntary and independent sector. We are continuing to work towards the launch of our new commercial model, with support from the Procurement Team and Commercial Team.

3.3.6 Mandatory & Essential Training: We are delivering training to the Children and Families Health Devon staff which mean's providing practical courses in Exeter and Barnstaple. Where possible we are linking in with other local trusts who are already delivering these mandatory training topics in these areas. For example - Staff will soon be able to access Devon Partnership NHS Trust's Conflict Resolution training courses in Barnstaple and Bideford. There are a number of bank staff who are out of date with some of their core mandatory training. We are working alongside the recruitment team to offer bank only dates to ensure these staff members are safe to practice. The team are producing inclusive online mandatory training to support volunteers and staff with additional learning needs to achieve their training. These staff members are also supported with one to one training when required. For example, one to one support with partially sighted staff member to achieve training which is only available online. We are reviewing the Corporate Induction Streamlining project that was introduced in June 2019. The results have shown that staff were not completing the E-induction section of the course. Actions we have put in place:

- The Hive team now attend day one of Corporate Induction to ensure all new staff have a log in.
- We demonstrate to all new starters how to access the E-induction pages and how to navigate the Hive.
- The training admin team will send a reminder via an email to all new starters after three months if they haven't completed the E-induction.

The clinical skills team are meeting with members of staff from the acute outreach team and vocational education team to review the way in which we deliver Early Warning Score training as the new early warning score is about to be run out within the trust. We are going to look at the ways in which this is trained to different levels of staff, and are going to be working with the other teams to ensure the levels of learning are appropriate for the roles of staff. This will promote a greater depth of thinking and analysis of observation data.

3.3.7 Resuscitation Team: The team are continuing to increase numbers of basic, intermediate and advanced life support courses to meet demand and to meet national standards and guidelines. Quality improvement is ongoing within the cardiac arrest team to train senior team members in debriefing after resuscitation attempts. The new defibrillator roll-out is almost complete now, with over 120 new defibrillators placed across the Trust and thousands of staff trained to use them by the team.

3.3.8 Digital Horizons: The team continue to explore and test new technology to support education and patient experience. This includes the use of virtual reality as wellbeing and distraction therapy and gamification techniques to support digital learning. Some of the team are now resident in the new Hi-Tech centre at

South Devon College. This give us a fantastic opportunity to utilise the latest facilities on offer, whilst developing the working relationship that we already have. The rest of the team have moved back to The Horizon Centre.

3.3.9 Medical Education: The Undergraduate team are continuing to meet with all departments across Torbay Hospital and our Community Hospitals; to discuss the implementation of the new Year 3&4 Undergraduate medical programme, due to start this September. These meetings have to-date been very successful and we continue to receive positive engagement from these services towards this new expansion. The Undergraduate team are pleased to announce that they have successfully appointed Dr Douglas Natusch, Consultant in Anaesthetics & Pain Medicine to the role of Plymouth Associate Dean. The Associate Dean role is a key leadership position for the locality and effectively upholds the core relationship between the University of Plymouth Medical School and the Trust. The Postgraduate team successfully co-ordinated the RCOP PACES in January 2020; receiving very positive feedback from the visiting chair, examiners, and patients. The Postgraduate service currently has a vacancy within the Director of Medical Education role. However, Mr Ian Currie is kindly working with the team to facilitate a successful appointment.

3.3.10 Library & Information Services: The library team are taking the lead on a project to implement a new library management system across all NHS libraries in the South of England with a go-live date in March 2020, are heavily involved in a procurement process to purchase a national system across England for the first time, and a project to connect online authentication to library-purchased resources via ADFS in our Trust (currently used with the Hive) to enable single-sign on.

3.4 Medical Workforce & OD

3.4.1 Medical Agency Reduction Plans (January 2020): We are seeing an increase in service demand across the Trust, the locum agency is in response to covering existing gaps and meeting this demand and is not an overall expansion of medical staff. Service redesign is looking at the increase workload of medical staff to identify what we can deliver both now and in the future.

3.4.2 Current Medical Locum Agency

Rank	Speciality	Min Trust Start	Max Trust End	Booking Value
1	Dermatology	08/01/2018 08:30	24/01/2020 17:00	£272,123
2	Dermatology	03/09/2018 08:30	06/03/2020 17:00	£142,353
3	Neuro	25/11/2019 09:00	29/05/2020 17:00	£129,588
4	Acute Internal Med	25/02/2019 08:00	27/03/2020 18:00	£124,576

3.4.2.1 Dermatology:

- 3 Locums currently covering vacancies
- All 3 within top 5 high cost areas
- Service has seen a 10% growth
- Data has been collated around work undertaken by locums which has demonstrated 40% of work carried out by locum 1 can be undertaken by a nurse and 25% of work carried out by locum 2 can be undertaken by a nurse.
- In response to this the service is working on creating a Nurse Consultant role to alleviate the need for locum consultants.
- The service is also continuing its work with speciality GP attached to Practices to enable some dermatology to be undertaken within the GP Practice preventing the referral to the hospital-based service.

3.4.2.2 Neurology

- 2 Locums currently covering vacancies
- Both within top 5 high cost areas
- Service is currently consultant driven.
- Currently supported by a GP but have a registrar vacancy.
- Training nurses in outpatients to deliver some treatment in relation to headaches.
- Hopeful that will be able to recruit to one locum post later this year.

3.4.2.3 Acute Medicine

- 4 locums - 2 Consultants and 2 registrars
- Service is looking at how they use Physicians Associates in different ways to support the trainee doctor workforce. However, there is concern over the 1WTE budget shortfall for this role.
- Stroke are exploring a joint appointment with the RD&E together with reducing ward coverage to only see stroke patients as opposed to all general medicine.

3.4.2.4 Obs & Gynae

- Consultant locum due to sickness absence cover.
- Department is being supported by HR to manage the absence of the individual and plan a return to work.

3.4.3 Workforce Planning Physician Associates: We are currently working with departments to secure funding for the current cohort of PAs (x6) and re-modelling the last cohort of Physician Associates to ensure funding is in place for the posts and they are being placed in areas which have trainee doctor vacancies/gaps. This in turn should develop a new model of medical workforce to alleviate the issues of junior doctor vacancies. The GMC have confirmed that they will be the registration body for Physicians Associates, although there is no timeframe at present. As a registered profession this will lend itself to enabling these individuals to prescribe which in turn will enable them to more fully support our medical workforce.

3.4.4 Medical Job Planning System Procurement: The current IT system for job planning has been in place since 2008. Therefore, this is an opportunity to test the market for other options of systems which may provide better functionality than the current model and more value for money. We have been working with procurement to ensure tenders meet the system specification and are within framework. We plan to invite bidders to presentations on Wednesday 26th

February and have invited interested parties including operational managers, clinical leads and medical staff.

3.4.5 Review of SAS Recruitment and Induction Processes: Working with the Chair of our SAS staff group to review local process ensuring recruitment documentation is fit for purpose and managers understand the minimum knowledge skill and experience for Speciality Doctor versus Associate Specialist. Local induction arrangements are also being reviewed as part of the wider New Consultant and SAS development programme.

3.4.6 Consultants & SAS Recruitment/Vacancies January 2020

Job Title	Hours/PA's Approved	Perm/FT	Comments
Consultant in Anaesthesia	20PA's	Permanent	1 x candidate started in November. 1 x candidate starting 06/04/2020
Consultant Colorectal Surgeon	10PA's	Permanent	Advert due to close 01/03/2020
Consultant Upper GI Surgeon	10PA's	Permanent	Appointed candidate due to start 01/09/2020
Consultant in Respiratory Medicine	10 PA's	Permanent	Appointed candidate due to start 15/04/2020
Consultant Physician in Stroke Medicine	10PA's	Permanent	Advert due to close 26/01/2020
Consultant in Oncology	20PA's	Permanent	Interview date 26/02/2020
Consultant in Emergency Medicine	10PA's	Permanent	Interview date 22/01/2020
Consultant Paediatrician	10PA's	Permanent	Candidate recently appointed start date TBC
Consultant Cellular Pathologist	10PA's	Permanent	Advert due to close 09/02/2020
Consultant in Healthcare of the Older Person	10 PA's	Permanent	Advert closed 19/01/2020 – Interview date 26/02/2020
Specialty Doctor in Emergency Medicine	10 PA's	Permanent	Advert closed 19/01/2020 Interview TBC
Consultant in Acute Medicine	10PA's	Permanent	Advert due to close 17/02/2020
Consultant Haematologist	10PA's	Permanent	Advert due to close 27/02/2020
Specialty Doctor/GP in Acute Medicine		FT 3m	Extended contract Candidate in post
Consultant Oncologist	10 PA's	FT 12m	Advert due to close 17/02/2020

4. Talent Management/Succession Report:

4.1 We are the first High Potential Scheme (HPS) pilot which has been given approval to include system partners and welcome a cohort from the whole of health and care in Devon. We are excited about the opportunities this unique approach offers to individuals, organisations and the system. We are working towards applications opening in early March.

4.1.3 The Trust has taken part in piloting a Talent Diagnostic Tool, with support from the South West Leadership Academy. An associated draft plan was presented to the People Committee however it was agreed this should not be a standalone piece of work but should be aligned to the People Plan – Great Place to Work engagement programme to avoid duplication of work.

4.1.4 It was agreed for a deep dive of current appraisals to take place and report back at April People Committee.

5. Future reporting – People & Organisational Development

Reflecting the strategic direction of the Trust and the key strategic planning areas underpinning the success of the future hospital redesign programme, it is intended that future board reports will be structure to align with the People Plan programme of work. The intention is that this will commence from the next Board report submission.

Report to the Trust Board of Directors		
Report title: Estates and Facilities – Top line briefs, EFM performance, compliance and exception report		Meeting date: 5th February 2020
Report appendix	Appendix 1 – Estates Performance and Compliance Report	
Report sponsor	Director of Estates and Commercial Development	
Report author	Associate Director, Estates and Facilities Operations	
Report provenance	Capital Infrastructure and Environment Group EFM Performance and Compliance Group Executives	
Purpose of the report and key issues for consideration/decision	The report is intended to provide an update to the Board on EFM key issues, performance and compliance for November and December 2019 **Top Line Briefs** **EFM Performance** EFM key performance indicators remain good across all areas with all estates statutory and mandatory planned preventative maintenance completed to plan. The age of the estate continues to represent a significant risk. There were 8 critical estate failures in November and December 2019 a number of which adversely affected activity and staff ad patient experience. • Top of Acute Site Heating failed - pipe collapsed but repaired. • Low Humidity in Theatres - issues continue and being managed by mechanical and clinical teams as problems arise. • Tower Block Lift C failed – motor drive system repaired. • Multiple critical area leaks following prolonged heavy rain – significant capital investment required to replace roofing. • Hetherington (G) – hot water BMS control unit failed one replaced one modified to manual control (base unit obsolete). • Fire Hydrant out of action near Bayview – hydrant isolated awaiting a complex repair. Limited risk as there is another adjacent hydrant. Fire service aware. • Cadewell Entrance street lighting – existing (concentric) cabling has a fault and requires replacement. **Commentary on EFM Compliance** • **Fire -** The Authorised Engineer (Fire) will be on site week commencing 27th January 2020 to revalidate fire compartmentation across the acute site. This will identify any residual remedial works required around fire dampers and fire doors. An action plan will be produced on completion of the AE findings and managed through the EFM Compliance Group.	

- **PAT Testing -** Annual PAT Testing within the Trust will commence on the 1st February 2020 and complete April 2020.
- **Generator Testing -** Monthly site load tests are in date and all generators are functional. Totnes Hospital Generator work completed 8th December and capital approval requested for Sub-Station 2 Enclosure and Exhaust repair. The annual servicing and load performance tests (due for 8 of the 13 generators) will be carried out in December 2019 / January 2020.
- **Waste -** The Trust is currently on incineration only for all clinical waste due to issues with segregation of waste streams. An action plan is in placed and for additional assurance an external waste consultant has been commissioned to review all waste processes and policies within the Trust.
- **Sharps -** The trial of Biosystems (reusable sharp containers) commenced on the 6th January 2020 which will aid the reduction of single use plastic and improve waste segregation.

New Ways of Working Trial

In collaboration with staff and staff side colleagues, a co-designed new way of working has been developed to address staff concerns, cleaning hours and dedicated catering responsibilities. A trial commenced on Midgely Ward on the 6th January 2020. The trial includes the implementation of a bespoke catering role and additional cleaning resources at ward level to manage discharge cleans, instead of referring to the centralised deep cleaning team. It is anticipated that this model will prove a more efficient use of resources. Outcome measures i.e. food safety standards, speed of cleaning and turnaround of side rooms and bed spaces are all positive within two weeks of the trial starting.

The clinical team have responded very favourably to the changes. An unsolicited e-mail from the Sister on Midgley says

"Midgley ward has felt amazing during this last 2 weeks with the new way of working with the Domestics.

Several staff have said how much cleaner and tidier the ward feels. I feel there is notably less stress from the Domestics around meal times which has a positive outcome with the patients.

We have had our sideroom's deep cleaned and turned around in 30 minutes which is good for patient flow.

Lynn* (Northcott the EFM Manager leading the change) *has been a positive influence throughout and has encouraged her team to push through any anxiety they have, to see the benefits to themselves and the ward."

The summary report is attached with the EFM Compliance and Performance report appended at Appendix 1 for information.

Action required (choose 1 only)	For information ☐	To receive and note ☒	To approve ☐
Recommendation	The Trust Board is asked to receive and note the: • Top line briefs for EFM for the months of November and December • EFM Compliance and Performance Reports and exceptions		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership		**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	X	**Risk score**	25
Risk Register	X	**Risk score**	25

External standards affected by this report and associated risks

Care Quality Commission	X	**Terms of Authorisation**	X
NHS Improvement	X	**Legislation**	X
NHS England	X	**National policy/guidance**	X

Report title: Estates and Facilities – Top line briefs, performance and exception report		**Meeting date: 5/2/2020**
Report sponsor	Director of Estates and Commercial Development	
Report author	Associate Director, Estates and Facilities Operations	

1. Estates and Facilities Operations – Key Issues and Exceptions report for November and December 2019.

This report aims to summarise and highlight key concerns and exceptions regarding Estates and Facilities Operations performance for the months of November and December 2019 and should be read in conjunction with the associated Section 2 Performance Table.

Table 1 below identifies the Key Performance Indicators variances for Estates and Facilities performance for the months of November and December 2019. Any areas of specific cause for concern for the attention of Trust Board are shown with appropriate explanation and action to achieve a resolution is shown at Table 2 below.

Table 1: November and December 2019 Scorecard Indicator.

Green □	Amber !	Red □	**Last Month**	**This Month**
Deteriorating Indicators				
Estates – Portable Appliance Testing - % in date			□	□
Waste - % of Total tonnage of Clinical Burn waste per month			□	□
Improving Indicators				
Estates – Routine PPM % success against plan			!	□
Estates - Urgent % P2 completed in <1 – 4 Days			!	□
Estates - Routine % P3 completed in <7 Days			□	!
Estates - Routine completed in <30 Days			!	□
Estates – Emergency Generator Compliance - % in date			□	□
Waste - % of Total tonnage of recycled waste per month			!	□
Waste - % of Total tonnage of clinical non-burn waste per month			□	!
Waste - % of Total tonnage of clinical offensive waste per month			□	!
Safety – EFM Incidents resulting in Moderate harm			!	□
Red rated Indicators with no change				
Estates – Internal Critical Failures			□	□
Estates - Fire Dampers Compliance - % in date			□	□

Table 2: Areas with Specific Cause for Concern	
Estates	**Estates Critical failures December 2019**
Explanation	1. Hetherington (G) – hot water BMS control unit failed – replaced 2. Hetherington (E) – hot water BMS controller failed – modified to manual control (base unit obsolescent). 3. Fire Hydrant out of action near Bayview – hydrant isolated awaiting a complex repair (need to dig across several essential services). There is another hydrant immediately adjacent to the Copper Silver treatment cab opposite the Bayview loading bay. Fire Service notified. 4. Cadewell Entrance street lighting – existing (concentric) cabling is not compliant so alternative power supply used to restore lighting. 5. Top of Acute Site Heating failed - pipe collapsed but repaired. 6. Low Humidity in Theatres - issues continue and being managed by Estates Mechanical teams and clinical teams as problems arise. 7. Tower Block Lift C – motor drive system repaired. 8. Multiple critical area leaks following prolonged heavy rain – significant capital investment required to replace roofing
Estates	**Fire Dampers Compliance - % in date**
Explanation	Following Fire Damper testing in July and November 2019, of 992 Fire Damper assets identified to date, 610 were tested successfully (61.5%) and a 5 failed their test due to defects (including installation defect) - (0.6% of total, or 1.0% of tested assets). 376 Fire dampers were not tested as they were inaccessible (37.9% of the total). The absolute compliance score for Fire damper testing is therefore 61.5%, although of those tested to date, 99.0% functioned correctly. The Fire AE will be reviewing Fire Compartmentation and Fire Dampers in the week commencing the 27th Jan 2020.
Estates	**Estates – Portable Appliance testing - % in date**
Explanation	PAT testing is organised Trust wide from 1st February via an external contractor
Estates	**Generator Servicing Compliance - % in date (13 Generators)**
Explanation	Totnes Hospital Generator work completed 8th December and capital approval requested for Sub-Station 2 Enclosure and Exhaust repair. The annual servicing and load performance tests (due for 8 of the 13 generators) will be carried out in December 2019 / January 2020. Monthly site load tests are still in date and all generators are functional.
Waste	**% Total Tonnage of Clinical Burn Waste per month**
Explanation	The Trust was placed on incineration only for all clinical waste in December 2019 for an initial 3 months due to non-segregation of the Tiger and clinical waste streams within the Trust. The potential for our clinical waste being sent in Tiger bags to landfill was too high. An action plan has been implemented with the use of an external waste auditor to help us return to our normal waste streams. On a positive note. We have started the implementation of Biosystems (reusable sharp containers) which will help to improve segregation and will start to reduce the use of single use plastic . This has been rolled out from the 6th January to seven trial areas (AMU, delivery Suite, Dunlop, DSU, Theatres, Ricky Grant and Turner).

Estates	**Fixed Wire Testing Compliance - % in date**
Explanation	Tender completed and procurement will provide access to the framework for selecting suppliers to be assessed for the award of work for the next five years. This work is not expected to be complete within this financial year and AE(LV) advice is being sought regarding risk.
Estates	**LEVs Testing Compliance - % in date**
Explanation	Survey in progress to capture all LEVs in use across the Trust. All LEVs that are recorded in the Estates Insurance Inspection Schedule are in date.
Estates	**Pressure Systems Compliance - % in date**
Explanation	Review is ongoing for the variances between the LMP and HSB compliance tracking systems. Significant progress has been made to improve records and monitoring.
Estates	**Asbestos Inspections Compliance - % in date**
Explanation	A further review meeting on 16th Jan 2020 confirmed a further visit is required to Kings Ash House and access is being arranged for Union House and Walnut Lodge. The Contractor has the dates when Estates have booked access to Theatres and the Bowyer Building surveying is 90% complete.
Catering	**EHO Audit Scores – Acute Site**
Explanation	The HACCP document has been reviewed and food safety within the ward Kitchens is being audited and targeted.

Estates and Facilities Operations Compliance Issues and Exceptions.

Main exceptions –

- Medical Gases Pipe Systems – The Medical Gases Policy final draft has been completed to reflect that the clinical lead for each ward/department is responsible for the control of Medical Gas in their area and would authorise the switching on / off of Medical Gas supplies in their area. The draft is expected to be forwarded to The Medical Gas Committee for the next stage of review prior to final approval by the Health and Safety Committee.

2. Estates and Facilities Operations Top Concerns.

Fire Dampers - Following the November testing round The absolute compliance score for Fire damper testing stands at is 61.5%, although of those tested to date, 99.0% functioned correctly.

There are a number of reasons restricting access to the fire dampers that were unable to be tested from them being sealed behind, fixed ceilings, plant/walls to suspected asbestos issues. For assurance the Trust's Fire Compartmentation (maintenance of patient safety) will be revalidated by the AE (Fire) during his visit on 27th – 31st January 2020 as part of the action plan to target the completion of Fire Damper remedial works.

3. Estates and Facilities Operations Action Plans.

Action Plans

- **Fire** – The progress of the AE (Fire) Action plan continues to be monitored by the Head of SSEP. The AE (Fire) will be conducting a verification of Fire Compartmentation, Fire Dampers, Tower Block Fire Strategy and the proposed Bells and Sounders Fire Alarms remediation plan w/c 27th January 2020

- **EHO** – Action plan – effort is being focussed on monitoring the HACCP document and food safety within the ward kitchens. The "New ways of working" trial commenced 6th January 2020 which included the implementation of a bespoke catering role. Within the first 2 weeks of the trial, the catering audits on the trial ward have seen a 100% compliance around food safety.
- **Waste** – Currently all clinical waste is going to incineration for an initial period of 3 months due to non-compliance of waste being received by the contractor from the Trust. An action plan has been implemented to improve the waste segregation across the Trust. An external waste consultant has been appointed to audit the Trust waste processes and advice around improvements to ensure future compliance is achieved.
- **HSE** – Action plan- The progress of the action plan continues to be monitored by the Site Services Lead. Outstanding actions are primarily around failed street lighting across the site, capital funding has been applied through the 2020/21 Capital plan. 2 new risks have been added to the Risk Register around failed lighting at Cadewell Lane as a result of deteriorated underground cabling resulting in failed street lighting and pedestrian crossing beacons in the area. Reversing vehicles in the Fracture clinic area continue to be a significant concern as the NHS Procurement vehicles continue to access the area without trained banks men. A meeting is being held with the Head of Procurement w/c 27th January 2020 to review the processes which were put in place following the issuing of the HSE improvement notice
- **Compliance** – The Canty Compliance Audit score remains at 70.41%, although this is undergoing regular review and will improve with each round as working practices ratifications, Policy updates and Roles and Responsibilities appointments are updated. Risk Assessment training for the Estates management team is scheduled for 21st February 2020.

4. Recommendations.

The Trust Board is asked to receive and note the:

- Top line briefs for EFM for the months of November and December 2020
- EFM Performance Reports and exceptions– Annex 1

EFM Performance Report

Domain	Estates & Facilities Operations Performance Data Nov-Dec 19 for Jan 2020 Report	2018-19 Quarter Four			2019-20 Quarter One			2019-20 Quarter Two			2019-20 Quarter Three			2019-20 Quarter Four			Trend	YTD 2019 to 2020	Average to date	Target 2019-20	RAG Threshold			Comments
		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Estates - Planned & Reactive work Performance	Total PPMs planned per month (not KPI)	1,071	956	1,080	979	1,374	1,051	1,178	1,067	1,206	951	1,057	0	0	0	0		11970	1088	Variable	11			Not a KPI - an indicator of volumes
	Statutory PPMs planned per month	403	369	398	347	796	443	444	398	430	364	386						4778	434	Variable				
	Statutory PPM % success against plan	98%	97%	98%	98%	98%	96%	100%	95%	100%	98%	98%							98%	97%	85%	85%	97%	
	Mandatory PPMs planned per month	453	444	432	485	422	441	505	449	552	431	438						5052	459	Variable				
	Mandatory PPM % success against plan	99%	98%	98%	97%	100%	97%	99%	99%	98%	98%	97%							98%	97%	85%	85%	95%	
	Routine PPMs planned per month	215	143	250	147	156	167	229	220	224	156	233						2140	195	Variable				
	Routine PPM % success against plan	76%	76%	88%	67%	58%	80%	89%	85%	87%	67%	93%							79%	90%	60%	60%	70%	
	Total Reactive Requests per month (not KPI)	995	882	901	851	910	974	1154	793	814	1028	1042	0	0	0	0		10344	940	Variable	11			Not a KPI - an indicator of volumes
	Emergency - P1 - requests per month	56	71	47	97	60	80	83	95	88	98	86						861	78	Variable				
	Emergency - % P1 completed in < 2hours	99%	99%	98%	100%	99%	99%	99%	99%	98%	100%	100%							99%	97%	90%	90%	95%	
	Urgent - P2 - requests per month	188	120	135	94	139	128	215	117	116	120	146						1518	138	Variable				
	Urgent – % P2 completed in < 1 - 4 Days	91%	91%	95%	98%	91%	85%	79%	87%	95%	87%	92%							90%	97%	85%	85%	90%	
	Routine - P3 - requests per month	601	556	591	543	564	604	686	487	510	668	664						6474	589	Variable				
	Routine - % P3 completed in < 7 Days	79%	81%	80%	90%	81%	82%	78%	73%	79%	72%	83%							80%	97%	75%	75%	85%	
	Routine - P4 - requests per month	150	135	128	117	147	162	170	94	100	142	146						1491	136	Variable				
	Routine - % P4 completed in < 30 Days	74%	73%	82%	86%	80%	79%	81%	79%	81%	67%	77%							78%	97%	65%	65%	75%	
	Estates Internal Critical Failures per month	6	2	4	3	0	3	5	2	5	4	5	3					42	3.5	0	2	1	0	
Estates - Statutory / Mandatory Compliance Performance	Fire Alarm Testing Compliance - % In date					100%	100%	99%	98%	99%	99%	98%	99%					Stat	99%	97%	85%	85%	97%	Midvale and Dartmouth Clinic to be completed.
	Emergency Lighting Compliance - % In date					99%	99%	98%	99%	100%	99%	99%	99%					Stat	99%	97%	85%	85%	97%	
	Fire Extinguisher Compliance - % In date					97%	96%	98%	97%	97%	97%	97%	98%					Stat	97%	97%	85%	85%	97%	Ext Contractor reports
	Fire Dry Risers Compliance - % In date					100%	100%	100%	100%	100%	100%	100%	100%					Stat	100%	97%	85%	85%	97%	Annual Testing in Progress
	Fire Hydrants Compliance - % In date					0%	0%	0%	0%	0%	100%	100%	100%					Stat	38%	97%	85%	85%	97%	LAFB completed successful test - 24 Oct 19
	Fire Dampers Compliance - % In date					93%	93%	93%	93%	93%	95%	62%	62%					Stat	85%	97%	85%	85%	97%	99% of tested Fire Dampers are good - see narrative
	Fire Supression Compliance - % In date					100%	100%	100%	100%	100%	100%	100%	100%					Stat	100%	97%	85%	85%	97%	
	Fixed Wire Testing Compliance - % In date					93%	93%	94%	93%	94%	94%	94%	94%					Stat	94%	97%	85%	85%	97%	
	Portable Appliance Testing - % in date					100%	100%	100%	100%	100%	100%	95%	83%					Mand	97%	97%	85%	85%	95%	Programme underway to address no access areas
	HV Equipment Compliance - % In date					100%	100%	100%	100%	100%	100%	100%	100%					Stat	100%	97%	85%	85%	97%	
	Generator Servicing Compliance - % In date					92%	92%	92%	92%	92%	38%	23%	38%					Mand	70%	97%	85%	85%	95%	8 of 13 PPMs due Oct + Sub 2 + Totnes Hosp (Exhaust)
	Lightning Protection Compliance - % In date					100%	100%	100%	100%	100%	100%	100%	100%					Stat	100%	97%	85%	85%	97%	
	Auto Door Inspection Compliance - % In date					100%	100%	100%	100%	100%	100%	100%	100%					Mand	100%	97%	85%	85%	95%	
	LEVs Testing Compliance - % In date					96%	96%	96%	92%	92%	92%	89%	89%					Stat	93%	97%	85%	85%	97%	
	Critical Vent Varification Compliance - % In date					97%	98%	94%	100%	97%	97%	100%	100%					Stat	98%	97%	85%	85%	97%	
	Kitchen + Extract Duct Clean Compliance - % In date					94%	94%	94%	94%	100%	100%	100%	100%					Stat	97%	97%	85%	85%	97%	
	Gas Pipework Compliance - % In date					95%	96%	71%	82%	93%	93%	86%	100%					Stat	90%	97%	85%	85%	97%	Main Energy Ctr Purchase Order approved
	Gas Appliance Compliance - % In date					100%	100%	100%	100%	100%	100%	96%	97%					Stat	99%	97%	85%	85%	97%	
	Landlord Gas Appliances Compliance - % In date					100%	100%	100%	100%	100%	100%	100%	100%					Stat	100%	97%	85%	85%	97%	
	Pressure Systems Compliance - % In date					95%	95%	95%	95%	95%	95%	95%	95%					Stat	95%	97%	85%	85%	97%	A different 5% to be completed each month.
	Window & Restrictor Insp Compliance - % In date					95%	96%	96%	96%	94%	96%	96%	96%					Mand	96%	97%	85%	85%	95%	
	Asbestos Inspections Compliance - % in date					75%	75%	80%	81%	93%	95%	95%	91%					Stat	86%	97%	85%	85%	97%	KAH, Theatres, Walnut + Union to be finished by Feb 20
	Water Safety Checks - works % in date					98%	97%	97%	98%	98%	97%	98%	98%					Stat	98%	97%	85%	85%	97%	Data From Shire Management System
	Edge protection Compliance - % In date					100%	100%	100%	100%	100%	100%	100%	100%					Stat	100%	97%	85%	85%	97%	
	Ladder Inspection Compliance - % In date					100%	100%	100%	100%	100%	100%	100%	100%					Stat	100%	97%	85%	85%	97%	

EFM Performance Report

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	Metrics	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20					Constant Review	Cause for Concern	No Concerns	
		Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Porters	Porters - Total Tasks per month	9436	8287	8793	8451	9275	8590	9292	8630	8346	9100	8704	8711					105615	8801	Variable				Not a KPI - an indicator of volume
	Porters - Bloods Tasks per month	2457	2083	2383	2278	2471	2422	2438	2218	2174	2393	2287	2186					27790	2316	Variable				
	Porters - Patient Transfer Tasks per month	2346	2019	2297	2096	2445	2144	2316	2289	2219	2217	2117	2169					26674	2223	Variable				
	Porters - Notes Tasks per month	1640	1431	1432	1542	1735	1521	1795	1623	1560	1928	1863	1698					19768	1647	Variable				
	Porters - Urgent Tasks per month	169	158	186	186	180	160	178	182	183	194	174	174						177	Variable				
	Porters - Routine Tasks per month	8995	7826	8307	7939	8827	7156	8786	8146	7841	8600	8266	8272						8247	Variable				
	Porters - Booked Tasks per month	272	303	300	326	268	274	327	302	322	306	264	265						294	Variable				
Cleaning	Scores - Brixham Hosp - High Risk			99%	99%	99%	99%	99%	99%	98%	98%	98%	98%						99%	95%	90%	90%	95%	
	Scores - Brixham Hosp - Significant Risk			99%	97%	99%	100%	100%	98%	98%	99%	97%	98%						98%	85%	80%	80%	85%	
	Scores - Brixham Hosp - Low Risk			99%	100%	100%	100%	100%	100%	99%	97%	94%	98%						99%	80%	75%	75%	80%	
	Scores - Dawlish Hosp - High Risk			100%	100%	100%	100%	100%	99%	98%	99%	98%	99%						99%	95%	90%	90%	95%	
	Scores - Dawlish Hosp - Significant Risk			100%	100%	100%	100%	100%	100%	100%	99%	98%	99%						100%	85%	80%	80%	85%	
	Scores - Newton Abbot Hosp - High Risk			99%	99%	100%	99%	99%	99%	100%	98%	97%	99%						99%	95%	90%	90%	95%	
	Scores - Newton Abbot Hosp - Significant Risk			99%	99%	99%	100%	98%	98%	98%	98%	98%	98%						98%	85%	80%	80%	85%	
	Scores - Newton Abbot Hosp - Low Risk			99%	97%	100%	99%	99%	99%	99%	99%	99%	98%						99%	80%	75%	75%	80%	
	Scores - Paignton H+WBC - High Risk			100%	96%	100%	100%	100%	99%	99%	99%	98%	98%						99%	95%	90%	90%	95%	
	Scores - Paignton H+WBC- Significant Risk			99%	98%	100%	99%	99%	99%	99%	99%	98%	98%						99%	85%	80%	80%	85%	
	Scores - Paignton H+WBC - Low Risk			98%	98%	99%	99%	99%	99%	98%	98%	95%	96%						98%	80%	75%	75%	80%	
	Scores - Teignmouth Hosp - Very High Risk			100%	100%	100%	100%	100%	99%	99%	99%	99%	98%						99%	98%	95%	95%	98%	Theatres Areas
	Scores - Teignmouth Hosp - High Risk			100%	100%	100%	100%	100%	100%	99%	99%	99%	98%						100%	95%	90%	90%	95%	
	Scores - Teignmouth Hosp - Significant Risk			100%	99%	100%	100%	99%	99%	99%	99%	99%	97%						99%	85%	80%	80%	85%	
	Scores - Torbay Hosp - Very High Risk			99%	99%	99%	99%	99%	99%	99%	98%	99%	98%						99%	98%	95%	95%	98%	Theatres Areas, Turner, ICU, A+E.
	Scores - Torbay Hosp - High Risk			97%	97%	99%	98%	98%	98%	98%	98%	97%	97%						98%	95%	90%	90%	95%	
	Scores - Torbay Hosp - Significant Risk			99%	98%	99%	99%	99%	98%	99%	98%	95%	96%						98%	85%	80%	80%	85%	
	Scores - Torbay Hosp - Low Risk			100%	85%	97%	100%	97%	97%	98%	98%	95%	95%						96%	80%	75%	75%	80%	
	Scores - Totnes Hosp - High Risk			100%	99%	99%	100%	98%	98%	99%	98%	98%	98%						99%	95%	90%	90%	95%	
	Scores - Totnes Hosp - Significant Risk			98%	99%	99%	99%	96%	96%	100%	95%	97%	98%						98%	85%	80%	80%	85%	
	Scores - Totnes Hosp - Low Risk			100%	98%	98%	100%	90%	90%	94%	95%	94%	96%						96%	80%	75%	75%	80%	
	HPV Cleans per month	25	11	13	11	21	31	35	21	22	41	20	20					271	23	Variable				From Porter data HPV data
	Deep Cleans per month	1018	1052	867	854	887	801	880	779	746	805	789	774					10252	854	Variable				From Porter data Deep Clean Categories (x5) data
	Annual Deep Cleans per month	7	1	5	7	4	1	5	9	34	9	4	4					90	8	Variable				Added Sep 19 from Porter data Periodic Cleans (Rooms).
	Critical Cleaning Failures	2	1	1	1	0	0	1	0	0	0	0	0					6	0.5	0	2	1	0	

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	Metrics	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20					Constant Review	Cause for Concern	No Concerns	
		Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Accom	Boyce Court Occupancy Void Costs	219	279	1224	0	381	340	1,323	0	479	329	329	0					4903	408.6	Variable	2000	2000	1000	IVs in arrears. 68 Flats, charges if 95%-70% full. Budget £24,312
	On-Site - Staff Accomodation Income				34,142	31,084	19,398	19,883	22,385	24,508	25,730	25,304	28,937					231371	25708	Variable	19256	19256	24391	Annual budget - £308,099
Catering	Patient Meals provided per month				31452	31461	31429	31458	31536	31557	31143	31351	33303					284690	31632	Variable				
	Meals purchased at Bayview Restaurant per month				3874	3917	4027	5848	5413	5769	6389	6292	5384					46913	5213	Trend				
	Meals purchased at Horizon Café per month				2791	2843	2807	2886	1991	2835	3035	3066	2022					24276	2697	Trend				
	Red Catering Trays per month				748	763	724	784	798	783	738	759	793					6890	766	Trend				Need to establish data collection method
	% of Catering Food Waste per month				2.0%	2.0%	3.0%	4.2%	3.9%	4.3%	4.1%	4.7%	4.4%						4%	5%	10.0%	10.0%	5.0%	
	EHO Audit Scores - Acute				2	2	2	3	3	3	3	3	3						2.7	5	2	2	4	
	EHO Audit Scores - Brixham Hospital				5	5	5	5	5	5	5	5	5						5.0	5	2	2	4	
	EHO Audit Scores - Dawlish Hospital				5	5	5	5	5	5	5	5	5						5.0	5	2	2	4	
	EHO Audit Scores - Newton Abbot Hospital				4	4	4	4	4	4	4	4	4						4.0	5	2	2	4	
	EHO Audit Scores - Totnes Hospital				5	5	5	5	5	5	5	5	5						5.0	5	2	2	4	
	Catering Audits								28	36	32	38	26						32.0	5	25	25	30	Added Sep 19
Waste	Total Tonnage all waste streams per month	202.9	168.6	152.5	161.0	185.0	161.7	182.1	165.3	175.3	176.1	148.0	179.2					2057.7	171.5	Trend				
	% of Total tonnage Recycled Waste per month	54.1%	50.4%	46.1%	47.4%	49.5%	50.1%	51.6%	46.4%	52.7%	47.2%	41.1%	53.3%						49%		40.0%	40.0%	47.0%	
	% of Total tonnage Landfill Waste per month	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						0%		5.0%	5.0%	2.0%	
	% of Total tonnage of Clinical Non-Burn waste per month	8.9%	9.8%	10.5%	10.1%	9.1%	10.7%	9.9%	10.6%	8.9%	9.4%	12.7%	5.5%						10%	100%	11.0%	9.0%	10.0%	
	% of Total tonnage of Clinical Burn waste per month	9.2%	10.7%	12.2%	10.8%	10.1%	10.5%	10.6%	11.0%	10.1%	11.1%	12.3%	20.1%						12%	100%	13.0%	9.0%	11.0%	Theatre Waste is incinerated to avoid contaminated waste being sent to contractor.
	% of Total tonnage of Clinical Offensive waste per month	9.5%	11.2%	12.0%	11.9%	10.6%	10.6%	11.9%	11.6%	10.9%	11.5%	13.7%	6.2%						11%		12.0%	10.0%	11.0%	
	% of Total Tonnage Waste to Energy	18.4%	17.9%	19.2%	19.9%	20.8%	18.1%	16.0%	20.4%	17.4%	20.7%	20.1%	15.0%						19%		35.0%	35.0%	24.0%	
	Total Waste to Energy (tonnes)	5.3	28.7	31.4	30.6	29.0	28.6	25.6	31.4	27.5	31.9	48.1	35.0					353.0	29.4	Trend				This figure does not necessarily match the % of the total
	Statutory Waste Audits - % completed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%						100%	Trend	90%	90%	95%	15 Audits per month

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		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Workforce	Total Estates and Facilities Staff (FTE)			380	387	391	392	393	390	394	398	398	398	0	0	0			392		10			Update no of Months in V94 for av in T94
	Estates Staff			34	34	34	34	34	32	34	34	35	37						34					
	Facilities Management			23	23	23	22	22	21	21	20	20	20						21					
	Hotel Services - Catering			33	33	33	33	33	33	33	33	33	33						33					
	Hotel Services - Domestic			216	223	227	230	231	230	231	234	234	233						229					
	Hotel Services - Other			74	74	74	74	74	75	76	78	78	76						75					
	Achievement Review Compliance %			96%	92%	95%	95%	93%	85%	85%	85%	85%	90%						90%	95%	80%	80%	90%	Estates 82% up from 35%, FM Mgt 83% up from 78%
	Sickness Absence % (Month Sick Rate)			4.4%	3.8%	3.0%	2.3%	4.5%	4.2%	5.1%	5.9%	5.0%							4.2%	3%	3.8%	3.8%	3.5%	1 month in arrears. (Catering 7.7%, Domestics - 7.8%)
	Mandatory Training - Conflict Resolution			95%	93%	96%	97%	93%	96%	95%	95%	94%	94%						95%	90%	75%	75%	85%	
	Mandatory Training - Equality & Diversity			97%	96%	98%	98%	98%	98%	95%	97%	97%	97%						97%	90%	75%	75%	85%	
	Mandatory Training - Fire Training			97%	96%	98%	97%	97%	98%	94%	97%	98%	95%						97%	90%	75%	75%	85%	
	Mandatory Training - Health & Safety			97%	95%	96%	98%	98%	98%	96%	98%	97%	97%						97%	90%	75%	75%	85%	
	Mandatory Training - Infection Control			95%	94%	96%	96%	97%	96%	94%	94%	94%	95%						95%	90%	75%	75%	85%	
	Mandatory Training - Information Governance			96%	94%	94%	94%	95%	97%	93%	94%	93%	92%						94%	95%	85%	85%	95%	Estates - 81%
	Mandatory Training - Moving & Handling			97%	97%	98%	99%	97%	96%	92%	95%	94%	96%						96%	90%	75%	75%	85%	
	Mandatory Training - Safeguarding Adult Level 1			97%	96%	99%	98%	99%	98%	98%	98%	97%	99%						98%	95%	80%	80%	90%	
	Mandatory Training - Safeguarding Children			97%	95%	96%	97%	98%	98%	96%	97%	97%	98%						97%	95%	80%	80%	90%	
	Mandatory Training - Resuscitation			90%	91%	92%	94%	94%	96%	93%	94%	94%	94%						93%	90%	75%	75%	85%	
	Mandatory Training - Basic Prevent Awareness			98%	97%	99%	99%	99%	98%	97%	97%	97%	98%						98%	90%	75%	75%	85%	
Safety	EFM Serious/RIDDOR incidents			0	1	0	0	0	0	0	0	0	0					1	0.1	0	2	1	0	
	EFM incidents resulting in moderate harm			1	2	0	2	1	2	0	1	2	1					12	1.2	0	3	3	1	Service User injured by Car Park Barrier - INC-58984
	EFM incidents resulting in minor harm			4	1	5	4	5	10	5	8	5	2					49	4.9	0	8	8	4	
	EFM incidents resulting in no harm			2	2	11	10	12	8	6	10	13	12					86	8.6	0	15	15	8	
	CAS Alerts active and in Progress	9	9	10	9	8	7	7	5	3	3	2	2						6	Variable				
	CAS Alerts Overdue for Completion	6	5	5	5	7	6	5	4	1	2	1	1						4.0	0	2	2	0	IT Zebra Printers CAS Alert